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Supreme Court, U.S.
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In The
Supreme Court of the United States

AMERICAN CHIROPRACTIC ASSOCIATION, INCORPORATED, a non-profit corporation, *et al.*,
*Petitioners,*

v.

TRIGON HEALTHCARE, INCORPORATED, *et al.*,
*Respondents.*

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

# APPENDIX B TO PETITION FOR WRIT OF CERTIORARI

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Quick Reference Guide for Clinicians

Number 14

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# Acute Low Back Problems in Adults: Assessment and Treatment

COMPLETED

U.S. Department of Health and Human Services
Public Health Service
Agency for Health Care Policy and Research

Acute Low Back Problems in Adults

TR03140242

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The Clinical Practice Guideline on which this Quick Reference Guide for Clinicians is based was developed by a multidisciplinary, private-sector panel comprising health care professionals and a consumer representative sponsored by the Agency for Health Care Policy and Research (AHCPR). Panel members were:

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Special consultants to the panel were: Michele Battié, PT, PhD; Claire Bombardier, MD; Nortin Hadler, MD; Alf Nachemson, MD, PhD; Gordon Waddell, MD. John Holland, MD, MPH and John Webster, MD served as project directors. Project methodologists were David Schriger, MD, MPH and Paul Shekelle, MD,MPH.

An explicit, science-based methodology was employed along with expert clinical judgment to develop specific statements on patient assessment and management on acute low back problems. Extensive literature searches were conducted and critical reviews and syntheses were used to evaluate empirical evidence and significant outcomes. Peer review and pilot testing were undertaken to evaluate the validity, reliability, and utility of the guideline in clinical practice.

This *Quick Reference Guide for Clinicians* presents a clinical strategy for applying the statements and recommendations from the *Clinical Practice Guideline*. The latter provides a description of the guideline development process, thorough analysis and discussion of the available research, critical evaluation of the assumptions and knowledge of the field, more complete information for health care decisionmaking, consideration for patients with special needs, and references. Decisions to adopt particular recommendations from either publication must be made by practitioners in light of available resources and circumstances presented by the individual patient.

AHCPR invites comments and suggestions from users for consideration in development and updating of future guidelines.

Please send written comments to:

Director, Office of the Forum for Quality and
Effectiveness in Health Care
AHCPR, Willco Building, Suite 310
6000 Executive Boulevard
Rockville, MD 20852



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Quick Reference Guide for Clinicians

Number 14

# Acute Low Back Problems in Adults: Assessment and Treatment


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**U.S. Department of Health and Human Services**
Public Health Service
Agency for Health Care Policy and Research
Rockville, Maryland

AHCPR Publication No. 95-0643
December 1994




TR03140244

## Abstract

This *Quick Reference Guide for Clinicians* contains highlights from the *Clinical Practice Guideline* version of *Acute Low Back Problems in Adults*, which was developed by a private-sector panel of health care providers and consumers. The *Quick Reference Guide* is an example of how a clinician might implement the panel's findings and recommendations on the management of acute low back problems in working-age adults. Topics covered include the initial assessment of patients presenting with acute low back problems, identification of red flags that may indicate the presence of a serious underlying medical condition, initial management, special studies and diagnostic considerations, and further management considerations. Instructions for clinical testing for sciatic tension, recommendations for sitting and unassisted lifting, tests for identification of clinical pathology, and algorithms for patient management are included.

## Suggested citation

This document is in the public domain and may be used and reprinted without special permission. AHCPR appreciates citation as to source and the suggested format is provided below:

Bigos S, Bowyer O, Braen G, et al. *Acute Low Back Problems in Adults.* Clinical Practice Guideline, Quick Reference Guide Number 14. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. AHCPR Pub. No. 95-0643. December 1994.



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## Purpose and Scope

Low back problems affect virtually everyone at some time during their life. Surveys indicate a yearly prevalence of symptoms in 50 percent of working age adults; 15-20 percent seek medical care. Low back problems rank high among the reasons for physician office visits and are costly in terms of medical treatment, lost productivity, and nonmonetary costs such as diminished ability to perform or enjoy usual activities. In fact, for persons under age 45, low back problems are the most common cause of disability.

Acute low back problems are defined as activity intolerance due to lower back or back-related leg symptoms of less than 3 months' duration. About 90 percent of patients with acute low back problems spontaneously recover activity tolerance within 1 month. The approach to a new episode in a patient with a recurrent low back problem is similar to that of a new acute episode.

The findings and recommendations included in the *Clinical Practice Guideline* define a paradigm shift away from focusing care exclusively on the pain and toward helping patients improve activity tolerance. The intent of this *Quick Reference Guide* is to bring to life this paradigm shift. The guide provides information on the detection of serious conditions that occasionally cause low back symptoms (conditions such as spinal fracture, tumor, infection, cauda equina syndrome, or non-spinal conditions). However, treatment of these conditions is beyond the scope of this guideline. In addition, the guideline does not address the care of patients younger than 18 years or those with chronic back problems (back-related activity limitations of greater than 3 months' duration).

## Initial Assessment

- Seek potentially dangerous underlying conditions.
- In the absence of signs of dangerous conditions, there is no need for special studies since 90 percent of patients will recover spontaneously within 4 weeks.

A focused medical history and physical examination are sufficient to assess the patient with an acute or recurrent limitation due to low back symptoms of less than 4 weeks duration. Patient responses and findings on the history and physical examination, referred to as "red flags" (Table 1), raise suspicion of serious underlying spinal conditions. Their absence rules out the need for special studies during the first 4 weeks of symptoms when spontaneous recovery is expected. The medical history and physical examination can also alert the clinician to non-spinal pathology (abdominal, pelvic, thoracic) that



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can present as low back symptoms. Acute low back symptoms can then be classified into one of three working categories:

- *Potentially serious spinal condition*—tumor, infection, spinal fracture, or a major neurologic compromise, such as cauda equina syndrome, suggested by a red flag.
- *Sciatica*—back-related lower limb symptoms suggesting lumbosacral nerve root compromise.
- *Nonspecific back symptoms*—occurring primarily in the back and suggesting neither nerve root compromise nor a serious underlying condition.

**Table 1. Red flags for potentially serious conditions**

| Possible fracture | Possible tumor or infection | Possible cauda equina syndrome |
|---|---|---|
| **From medical history** | | |
| Major trauma, such as vehicle accident or fall from height.<br><br>Minor trauma or even strenuous lifting (in older or potentially osteoporotic patient). | Age over 50 or under 20.<br><br>History of cancer.<br><br>Constitutional symptoms, such as recent fever or chills or unexplained weight loss.<br><br>Risk factors for spinal infection: recent bacterial infection (e.g., urinary tract infection); IV drug abuse; or immune suppression (from steroids, transplant, or HIV).<br><br>Pain that worsens when supine; severe nighttime pain. | Saddle anesthesia.<br><br>Recent onset of bladder dysfunction, such as urinary retention, increased frequency, or overflow incontinence.<br><br>Severe or progressive neurologic deficit in the lower extremity. |
| **From physical examination** | | |
| | | Unexpected laxity of the anal sphincter.<br><br>Perianal/perineal sensory loss.<br><br>Major motor weakness: quadriceps (knee extension weakness); ankle plantar flexors, evertors, and dorsiflexors (foot drop). |



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## Medical History

In addition to detecting serious conditions and categorizing back symptoms, the medical history establishes rapport between the clinician and patient. The patient's description of present symptoms and limitations, duration of symptoms, and history of previous episodes defines the problem. It also provides insight into concerns, expectations, and nonphysical (psychological and socioeconomic) issues that may alter the patient's response to treatment. Assessment tools such as pain drawings and visual analog pain-rating scales may help further document the patient's perceptions and progress.

A patient's estimate of personal activity intolerance due to low back symptoms contributes to the clinical assessment of the severity of the back problem, guides treatment, and establishes a baseline for recommending daily activities and evaluating progress.

Open-ended questions, such as those listed below, can gauge the need for further discussion or specific inquiries for more detailed information:

- *What are your symptoms?*
  - Pain, numbness, weakness, stiffness?
  - Located primarily in back, leg, or both?
  - Constant or intermittent?
- *How do these symptoms limit you?*
  - How long can you sit, stand, walk?
  - How much weight can you lift?
- *When did the current limitations begin?*
  - How long have your activities been limited? More than 4 weeks?
  - Have you had similar episodes previously?
  - Previous testing or treatment?
- *What do you hope we can accomplish during this visit?*

## Physical Examination

Guided by the medical history, the physical examination includes:

- General observation of the patient.
- A regional back exam.
- Neurologic screening.
- Testing for sciatic nerve root tension.

The examination is mostly subjective since patient response or interpretation is required for all parts except reflex testing and circumferential measurements for atrophy.



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## Addressing Red Flags

Physical examination evidence of severe neurologic compromise that correlates with the medical history may indicate a need for immediate consultation. The examination may further modify suspicions of tumor, infection or significant trauma. A medical history suggestive of non-spinal pathology mimicking a back problem may warrant examination of pulses, abdomen, pelvis, or other areas.

## Observation and Regional Back Examination

Limping or coordination problems indicate the need for specific neurologic testing. Severe guarding of lumbar motion in all planes may support a suspected diagnosis of spinal infection, tumor, or fracture. However, given marked variations among persons with and without symptoms, range-of-motion measurements of the back are of limited value.

Vertebral point tenderness to palpation, when associated with other signs or symptoms, may be suggestive of but not specific for spinal fracture or infection. Palpable soft-tissue tenderness is, by itself, an even less specific or reliable finding.

## Neurologic Screening

The neurologic examination can focus on a few tests that seek evidence of nerve root impairment, peripheral neuropathy, or spinal cord dysfunction. Over 90 percent of all clinically significant lower extremity radiculopathy due to disc herniation involves the L5 or S1 nerve root at the L4-5 or L5-S1 disc level. The clinical features of nerve root compression are summarized in Figure 1.

- *Testing for Muscle Strength.* The patient's inability to toe walk (calf muscles, mostly S1 nerve root), heel walk (ankle and toe dorsiflexor muscles, L5 and some L4 nerve roots), or do a single squat and rise (quadriceps muscles, mostly L4 nerve root) may indicate muscle weakness. Specific testing of the dorsiflexor muscles of the ankle or great toe (suggestive of L5 or some L4 nerve root dysfunction), hamstrings and ankle evertors (L5-S1), and toe flexors (S1) is also important.
- *Circumferential Measurements.* Muscle atrophy can be detected by circumferential measurements of the calf and thigh bilaterally. Differences of less than 2 cm in measurements of the two limbs at the same level may be a normal variation. Symmetrical muscle bulk and strength are expected unless the patient has a neurologic impairment or a history of lower extremity muscle or joint problem.
- *Reflexes.* The ankle jerk reflex tests mostly the S1 nerve root and the knee jerk reflex tests mostly the L4 nerve root; neither tests the L5 nerve root. The reliability of reflex testing can be diminished in the presence of adjacent joint or muscle problems. Up-going toes in response to stroking the plantar footpad (Babinski or plantar



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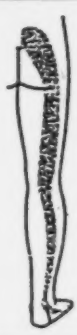
response) may indicate upper motor-neuron abnormalities (such as myelopathy or demyelinating disease) rather than a common low back problem.

- *Sensory Examination.* Testing light touch or pressure in the medial (L4), dorsal (L5), and lateral (S1) aspects of the foot (Figure 1) is usually sufficient for sensory screening.

**Figure 1. Testing for lumbar nerve root compromise.**

| Nerve root | L4 | L5 | S1 |
|---|---|---|---|
| Pain | | |  |
| Numbness | | | |
| Motor weakness | Extension of quadriceps. | Dorsilflexion of great toe and foot. | Plantar flexion of great toe and foot. |
| Screening exam | Squat & rise. | Heel walking. | Walking on toes. |
| Reflexes | Knee jerk diminished. | None reliable. | Ankle jerk diminished. |



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## Clinical tests for sciatic tension

*The straight leg raising (SLR) test* (Figure 2) can detect tension on the L5 and/or S1 nerve root. SLR may reproduce leg pain by stretching nerve roots irritated by a disc herniation.

**Figure 2. Instructions for the Straight Leg Raising (SLR) Test**

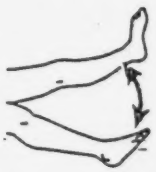
(1) Ask the patient to lie as straight as possible on a table in the supine position.

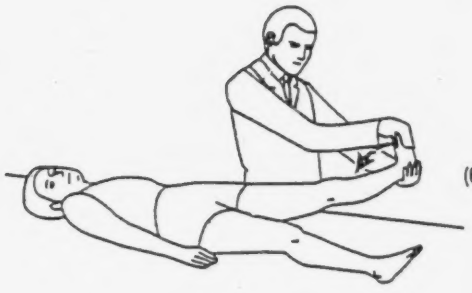
(2) With one hand placed above the knee of the leg being examined, exert enough firm pressure to keep the knee fully extended. Ask the patient to relax.

(3) With the other hand cupped under the heel, slowly raise the straight limb. Tell the patient, "If this bothers you, let me know, and I will stop."

4) Monitor for any movement of the pelvis before complaints are elicited. True sciatic tension should elicit complaints before the hamstrings are stretched enough to move the pelvis.

(5) Estimate the degree of leg elevation that elicits complaint from the patient. Then determine the most distal area of discomfort: back, hip, thigh, knee, or below the knee.





(6) While holding the leg at the limit of straight leg raising, dorsiflex the ankle. Note whether this aggravates the pain. Internal rotation of the limb can also increase the tension on the sciatic nerve roots.

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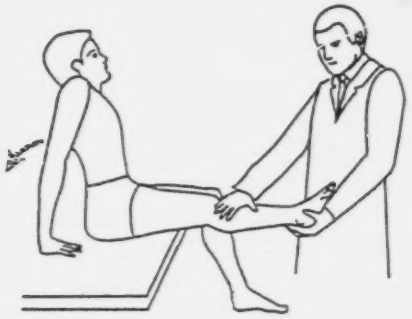
Pain below the knee at less than 70 degrees of straight leg raising, aggravated by dorsiflexion of the ankle and relieved by ankle plantar flexion or external limb rotation, is most suggestive of tension on the L5 or S1 nerve root related to disc herniation. Reproducing back pain alone with SLR testing does not indicate significant nerve root tension.

*Crossover pain* occurs when straight raising of the patient's well limb elicits pain in the leg with sciatica. Crossover pain is a stronger indication of nerve root compression than pain elicited from raising the straight painful limb.

*Sitting knee extension* (Figure 3) can also test sciatic tension. The patient with significant nerve root irritation tends to complain or lean backward to reduce tension on the nerve.

**Figure 3. Instructions for sitting knee extension test.**



With the patient sitting on a table, both hip and knees flexed at 90 degrees, slowly extend the knee as if evaluating the patella or bottom of the foot. This maneuver stretches nerve roots as much as a moderate degree of supine SLR.



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## Inconsistent Findings and Pain Behavior

The patient who embellishes a medical history, exaggerates pain drawings, or provides responses on physical examination inconsistent with known physiology can be particularly challenging. A strongly positive supine straight leg raising test without complaint on sitting knee extension and inconsistent responses on examination raise a suspicion that nonphysical factors may be affecting the patient's responses. "Pain behaviors" (verbal or nonverbal communication of distress or suffering) such as amplified grimacing, distorted gait or posture, moaning, and rubbing of painful body parts may also cloud medical issues and even evoke angry responses from the clinician.

Interpreting inconsistencies or pain behaviors as malingering does not benefit the patient or the clinician. It is more useful to view such behavior and inconsistencies as the patient's attempt to enlist the practitioner as an advocate, a plea for help. The patient could be trapped in a job where activity requirements are unrealistic relative to the person's age or health. In some cases, the patient may be negotiating with an insurer or be involved in legal actions. In patients with recurrent back problems, inconsistencies and amplifications may simply be habits learned during previous medical evaluations. In working with these patients, the clinician should attempt to identify any psychological or socioeconomic pressures that might be influenced in a positive manner. The overall goal should always be to facilitate the patient's recovery and avoid the development of chronic low back disability.



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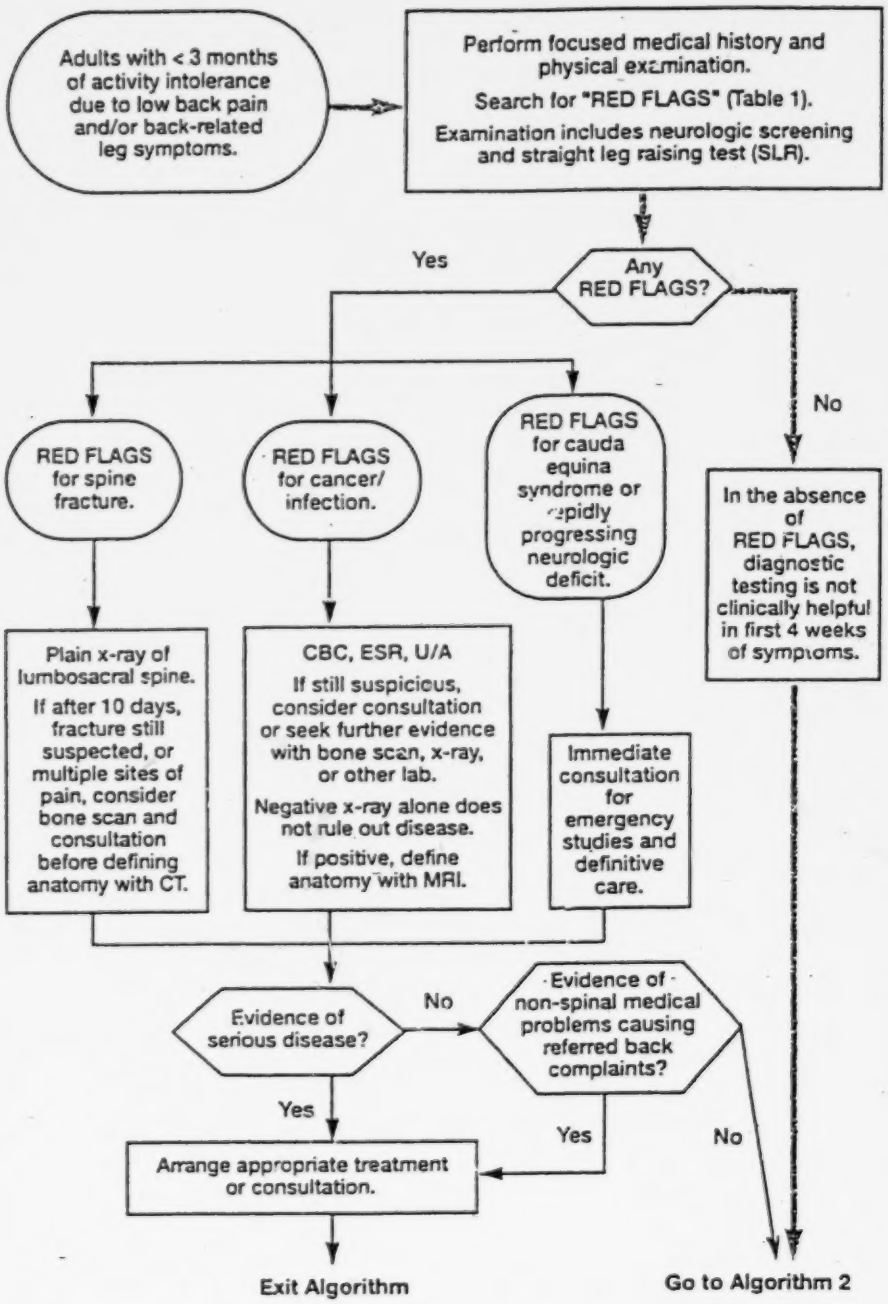
## Algorithm 1:
## Initial evaluation of acute low back problem


Adults with < 3 months of activity intolerance due to low back pain and/or back-related leg symptoms.
Perform focused medical history and physical examination.
Search for "RED FLAGS" (Table 1).
Examination includes neurologic screening and straight leg raising test (SLR).
Any RED FLAGS?
Yes
No
RED FLAGS for spine fracture.
RED FLAGS for cancer/ infection.
RED FLAGS for cauda equina syndrome or rapidly progressing neurologic deficit.
In the absence of RED FLAGS, diagnostic testing is not clinically helpful in first 4 weeks of symptoms.
Plain x-ray of lumbosacral spine.
If after 10 days, fracture still suspected, or multiple sites of pain, consider bone scan and consultation before defining anatomy with CT.
CBC, ESR, U/A
If still suspicious, consider consultation or seek further evidence with bone scan, x-ray, or other lab.
Negative x-ray alone does not rule out disease.
If positive, define anatomy with MRI.
Immediate consultation for emergency studies and definitive care.
Evidence of serious disease?
No
Evidence of non-spinal medical problems causing referred back complaints?
Yes
Yes
No
Arrange appropriate treatment or consultation.
Exit Algorithm
Go to Algorithm 2

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- Education and assurance.
- Patient comfort.
- Activity alterations.

## Patient Education

If the initial assessment detects no serious condition, assure the patient that there is "no hint of a dangerous problem" and that "a rapid recovery can be expected." The need for education will vary among patients and during various stages of care. An obviously apprehensive patient may require a more detailed explanation. Patients with sciatica may have a longer expected recovery time than patients with nonspecific back symptoms and thus may need more education and reassurance. Any patient who does not recover within a few weeks may need more extensive education about back problems and the reassurance that special studies may be considered if recovery is slow.

## Patient Comfort

Comfort is often a patient's first concern. Nonprescription analgesics will provide sufficient pain relief for most patients with acute low back symptoms. If treatment response is inadequate, as evidenced by continued symptoms and activity limitations, prescribed pharmaceuticals or physical methods may be added. Comorbid conditions, side effects, cost, and provider/patient preference should guide the clinician's choice of recommendations. Table 2 summarizes comfort options.

## Oral Pharmaceuticals

The safest effective medication for acute low back problems appears to be acetaminophen. Nonsteroidal anti-inflammatory drugs (NSAIDs), including aspirin and ibuprofen, are also effective although they can cause gastrointestinal irritation/ulceration or (less commonly) renal or allergic problems. Phenylbutazone is not recommended due to risks of bone marrow suppression. Acetaminophen may be used safely in combination with NSAIDs or other pharmacologic or physical therapeutics, especially in otherwise healthy patients.

Muscle relaxants seem no more effective than NSAIDs for treating patients with low back symptoms, and using them in combination with NSAIDs has no demonstrated benefit. Side effects including drowsiness have been reported in up to 30 percent of patients taking muscle relaxants.

Opioids appear no more effective than safer analgesics for managing low back symptoms. Opioids should be avoided if possible and, when chosen, used only for a short time. Poor patient tolerance and risks of drowsiness, decreased reaction time, clouded judgment, and potential misuse/dependence have been reported in up to 35 percent of patients. Patients should be warned of these potentially debilitating problems.



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## Table 2: Symptom control methods

| Recommended | | |
|---|---|---|
| **Nonprescription analgesics** | | |
| Acetaminophen (safest)<br>NSAIDs (Aspirin,[1] Ibuprofen[1]) | | |
| **Prescribed pharmaceutical methods** | **Prescribed physical methods** | |
| **Nonspecific low back symptoms and/or sciatica** | **Nonspecific low back symptoms** | **Sciatica** |
| Other NSAIDs[1] | Manipulation<br>(in place of medication or a shorter trial if combined with NSAIDs) | |
| **Options** | | |
| **Nonspecific low back symptoms and/or sciatica** | **Nonspecific low back symptoms** | **Sciatica** |
| Muscle relaxants[2,3,4]<br><br>Opioids[2,3,4] | Physical agents and modalities[2]<br>(heat or cold modalities for home programs only)<br><br>Shoe insoles[2] | Manipulation (in place of medication or a shorter trial if combined with NSAIDs)<br><br>Physical agents and modalities[2]<br>(heat or cold modalities for home programs only)<br><br>Few days' rest[4]<br><br>Shoe insoles[2] |

[1]Aspirin and other NSAIDs are not recommended for use in combination with one another due to the risk of GI complications.
[2]Equivocal efficacy.
[3]Significant potential for producing drowsiness and debilitation; potential for dependency.
[4]Short course (few days only) for severe symptoms.



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## Physical Methods

- ***Manipulation,*** defined as manual loading of the spine using short or long leverage methods, is safe and effective for patients in the first month of acute low back symptoms without radiculopathy. For patients with symptoms lasting longer than 1 month, manipulation is probably safe but its efficacy is unproven. If manipulation has not resulted in symptomatic and functional improvement after 4 weeks, it should be stopped and the patient reevaluated.
- ***Traction*** applied to the spine has not been found effective for treating acute low back symptoms.
- ***Physical modalities*** such as *massage, diathermy, ultrasound, cutaneous laser treatment, biofeedback,* and *transcutaneous electrical nerve stimulation (TENS)* also have no proven efficacy in the treatment of acute low back symptoms. If requested, the clinician may wish to provide the patient with instructions on self-application of heat or cold therapy for temporary symptom relief.
- ***Invasive techniques*** such as *needle acupuncture* and *injection procedures* (injection of trigger points in the back; injection of facet joints; injection of steroids, lidocaine, or opioids in the epidural space) have no proven benefit in the treatment of acute low back symptoms.
- ***Other miscellaneous therapies*** have been evaluated. No evidence indicates that *shoe lifts* are effective in treating acute low back symptoms or limitations, especially when the difference in lower limb length is less than 2 cm. Shoe insoles are a safe and inexpensive option if requested by patients with low back symptoms who must stand for prolonged periods. Low back corsets and back belts, however, do not appear beneficial for treating acute low back symptoms.



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## Activity Alteration

To avoid both undue back irritation and debilitation from inactivity, recommendations for alternate activity can be helpful. Most patients will not require bed rest. Prolonged bed rest (more than 4 days) has potential debilitating effects, and its efficacy in the treatment of acute low back problems is unproven. Two to four days of bed rest are reserved for patients with the most severe limitations (due primarily to leg pain).

**Avoiding undue back irritation.** Activities and postures that increase stress on the back also tend to aggravate back symptoms. Patients limited by back symptoms can minimize the stress of lifting by keeping any lifted object close to the body at the level of the navel. Twisting, bending, and reaching while lifting also increase stress on the back. Sitting, although safe, may aggravate symptoms for some patients. Advise these patients to avoid prolonged sitting and to change position often. A soft support placed at the small of the back, armrests to support some body weight, and a slight recline of the chair back may make required sitting more comfortable.

**Avoiding debilitation.** Until the patient returns to normal activity, aerobic (endurance) conditioning exercise such as walking, stationary biking, swimming, and even light jogging may be recommended to help avoid debilitation from inactivity. An incremental, gradually increasing regimen of aerobic exercise (up to 20 to 30 minutes daily) can usually be started within the first 2 weeks of symptoms. Such conditioning activities have been found to stress the back no more than sitting for an equal time period on the side of the bed. Patients should be informed that exercise may increase symptoms slightly at first. If intolerable, some exercise alteration is usually helpful.

Conditioning exercises for trunk muscles are more mechanically stressful to the back than aerobic exercise. Such exercises are not recommended during the first few weeks of symptoms, although they may later help patients regain and maintain activity tolerance.

There is no evidence to indicate that back-specific exercise machines are effective for treating acute low back problems. Neither is there evidence that stretching of the back helps patients with acute symptoms.



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## Work Activities

When requested, clinicians may choose to offer specific instructions about activity at work for patients with acute limitations due to low back symptoms. The patient's age, general health, and perceptions of safe limits of sitting, standing, walking or lifting (noted on initial history) can help provide reasonable starting points for activity recommendations. Table 3 provides a guide for recommendations about sitting and lifting. The clinician should make clear to patients and employers that:

- Even moderately heavy unassisted lifting may aggravate back symptoms.
- Any restrictions are intended to allow for spontaneous recovery or time to build activity tolerance through exercise.

Activity restrictions are prescribed for a short time period only, depending upon work requirements (no benefits apparent beyond 3 months).

**Table 3. Guidelines for sitting and unassisted lifting**

| | Symptoms | | | | | | |
|---|---|---|---|---|---|---|---|
| | Severe | → | Moderate | → | Mild | → | None |
| Sitting[1] | 20 min | → | → | → | → | → | 50 min |
| Unassisted lifting[2] | | | | | | | |
| Men | 20 lbs | → | 20 lbs | → | 60 lbs | → | 80 lbs |
| Women | 20 lbs | → | 20 lbs | → | 35 lbs | → | 40 lbs |

[1]Without getting up and moving around.
[2]Modification of NIOSH Lifting Guidelines, 1981, 1993. Gradually increase unassisted lifting limits to 60 lbs (men) and 35 lbs (women) by 3 months even with continued symptoms. Instruct patient to limit twisting, bending, reaching while lifting and to hold lifted object as close to navel as possible.



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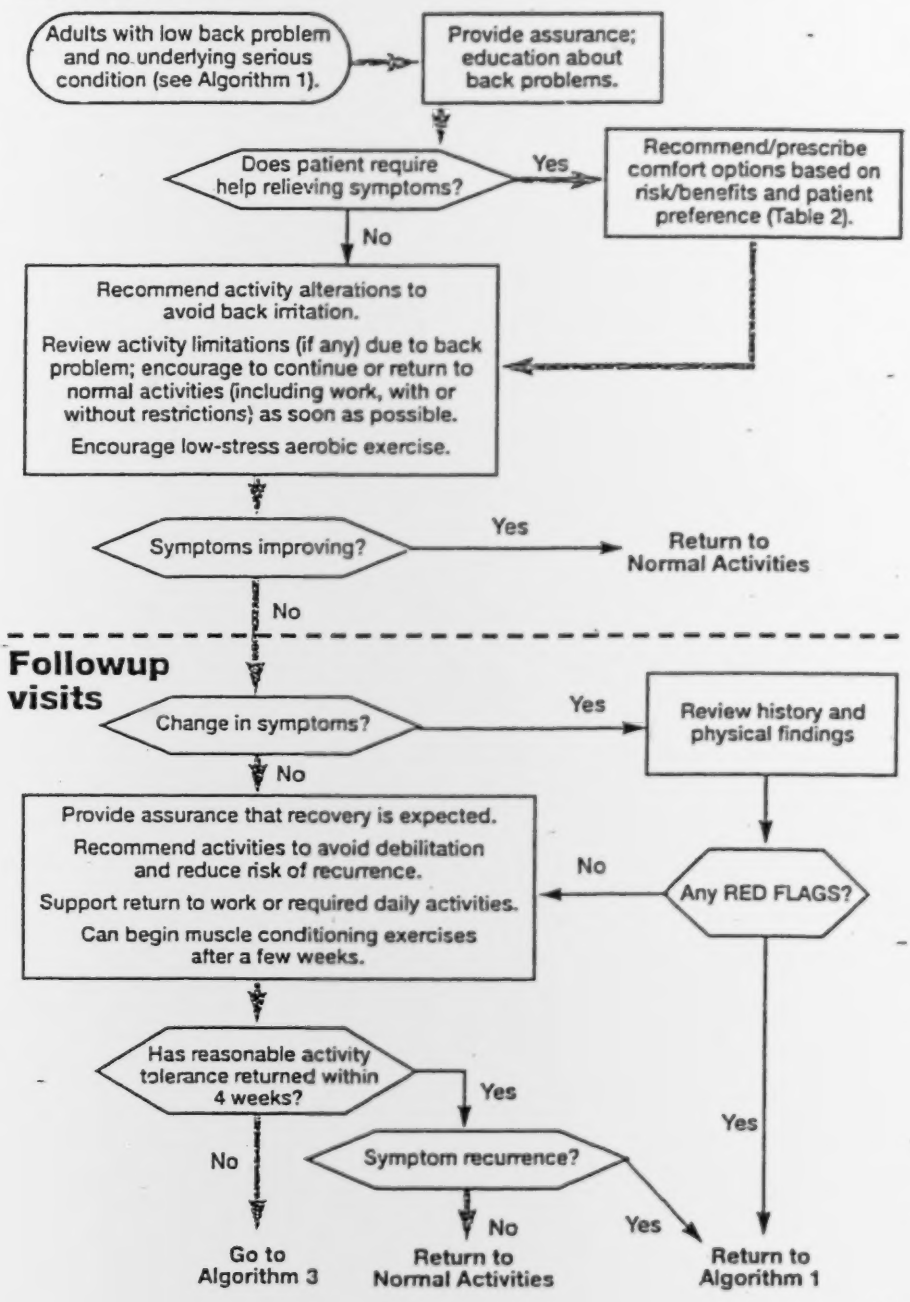
## Algorithm 2. Treatment of acute low back problem on initial and followup visits


Initial visit
Adults with low back problem and no underlying serious condition (see Algorithm 1).
Provide assurance; education about back problems.
Does patient require help relieving symptoms?
Yes
Recommend/prescribe comfort options based on risk/benefits and patient preference (Table 2).
No
Recommend activity alterations to avoid back irritation.
Review activity limitations (if any) due to back problem; encourage to continue or return to normal activities (including work, with or without restrictions) as soon as possible.
Encourage low-stress aerobic exercise.
Symptoms improving?
Yes
Return to Normal Activities
No
Followup visits
Change in symptoms?
Yes
Review history and physical findings
No
Provide assurance that recovery is expected.
Recommend activities to avoid debilitation and reduce risk of recurrence.
Support return to work or required daily activities.
Can begin muscle conditioning exercises after a few weeks.
No
Any RED FLAGS?
Has reasonable activity tolerance returned within 4 weeks?
Yes
Yes
No
Symptom recurrence?
No
Yes
Go to Algorithm 3
Return to Normal Activities
Return to Algorithm 1

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## Special Studies and Diagnostic Considerations

Routine testing (laboratory tests, plain x-rays of the lumbosacral spine) and imaging studies are not recommended during the first month of activity limitation due to back symptoms except when a red flag noted on history or examination raises suspicion of a dangerous low back or non-spinal condition. If a patient's limitations due to low back symptoms do not improve in 4 weeks, reassessment is recommended. After again reviewing the patient's activity limitations, history, and physical findings, the clinician may then consider further diagnostic studies, and discuss these with the patient.

### Timing and Limits of Special Studies

Waiting 4 weeks before considering special tests allows 90 percent of patients to recover spontaneously and avoids unneeded procedures. This also reduces the potential confusion of falsely labeling age-related changes on imaging studies (commonly noted in patients older than 30 without back symptoms) as the cause of the acute symptoms. In the absence of either red flags or persistent activity limitations due to continuous limb symptoms, imaging studies (especially plain x-rays) rarely provide information that changes the clinical approach to the acute low back problem.

### Selection of Special Studies

Prior to ordering imaging studies the clinician should have noted either of the following:

- The emergence of a red flag.
- Physiologic evidence of tissue insult or neurologic dysfunction.

Physiologic evidence may be in the form of definitive nerve findings on physical examination, electrodiagnostic studies (when evaluating sciatica), and a laboratory test or bone scan (when evaluating nonspecific low back symptoms). Unquestionable findings that identify specific nerve root compromise on the neurologic examination (see Figure 1) are sufficient physiologic evidence to warrant imaging. When the neurologic examination is less clear, however, further physiologic evidence of nerve root dysfunction should be considered before ordering an imaging study. Electromyography (EMG) including H-reflex tests may be useful to identify subtle focal neurologic dysfunction in patients with leg symptoms lasting longer than 3-4 weeks. Sensory evoked potentials (SEPs) may be added to the assessment if spinal stenosis or spinal cord myelopathy is suspected.

Laboratory tests such as erythrocyte sedimentation rate (ESR), complete blood count (CBC), and urinalysis (UA) can be useful to screen for nonspecific medical diseases (especially infection and tumor) of the low back. A bone scan can detect physiologic reactions to suspected spinal tumor, infection, or occult fracture.

Should physiologic evidence indicate tissue insult or nerve impairment, discuss with a consultant selection of an imaging test to define



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a potential anatomic cause (CT for bone, MRI for neural or other soft tissue). Anatomic definition is commonly needed to guide surgery or specific procedures. Selection of an imaging test should also take into consideration any patient allergies to contrast media (myelogram) or concerns about claustrophobia (MRI) and costs. A discussion with a specialist on selection of the most clinically valuable study can often assist the primary care clinician to avoid duplication. Table 4 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. Missing from the table is discography, which is not recommended for assessing patients with acute low back symptoms.

In general, an imaging study may be an appropriate consideration for the patient whose limitations due to consistent symptoms have persisted for 1 month or more:

- When surgery is being considered for treatment of a specific detectable loss of neurologic function.
- To further evaluate potentially serious spinal pathology.

Reliance upon imaging studies alone to evaluate the source of low back symptoms, however, carries a significant risk of diagnostic confusion, given the possibility of falsely identifying a finding that was present before symptoms began.

**Table 4. Ability of different techniques to identify and define pathology**

| Technique | Identify physiologic insult | Define anatomic defect |
|---|---|---|
| History | + | + |
| Physical examination: | | |
| Circumference measurements | + | + |
| Reflexes | ++ | ++ |
| Straight leg raising (SLR) | ++ | + |
| Crossed SLR | +++ | ++ |
| Motor | ++ | ++ |
| Sensory | ++ | ++ |
| Laboratory studies (ESR, CBC, UA) | ++ | 0 |
| Bone scan[1] | +++ | ++ |
| EMG/SEP | +++ | ++ |
| X-ray[1] | 0 | + |
| CT[1] | 0 | ++++[2] |
| MRI | 0 | ++++[2] |
| Myelo-CT[1] | 0 | ++++[2] |
| Myelography[1] | 0 | ++++[2] |

[1]Risk of complications (radiation, infection, etc.): highest for myelo-CT, second highest for myelography, and relatively less risk for bone scan, x-ray, and CT.

[2]False-positive diagnostic findings in up to 30 percent of people without symptoms at age 30.

**Note:** Number of plus signs indicates relative ability to identify or define.



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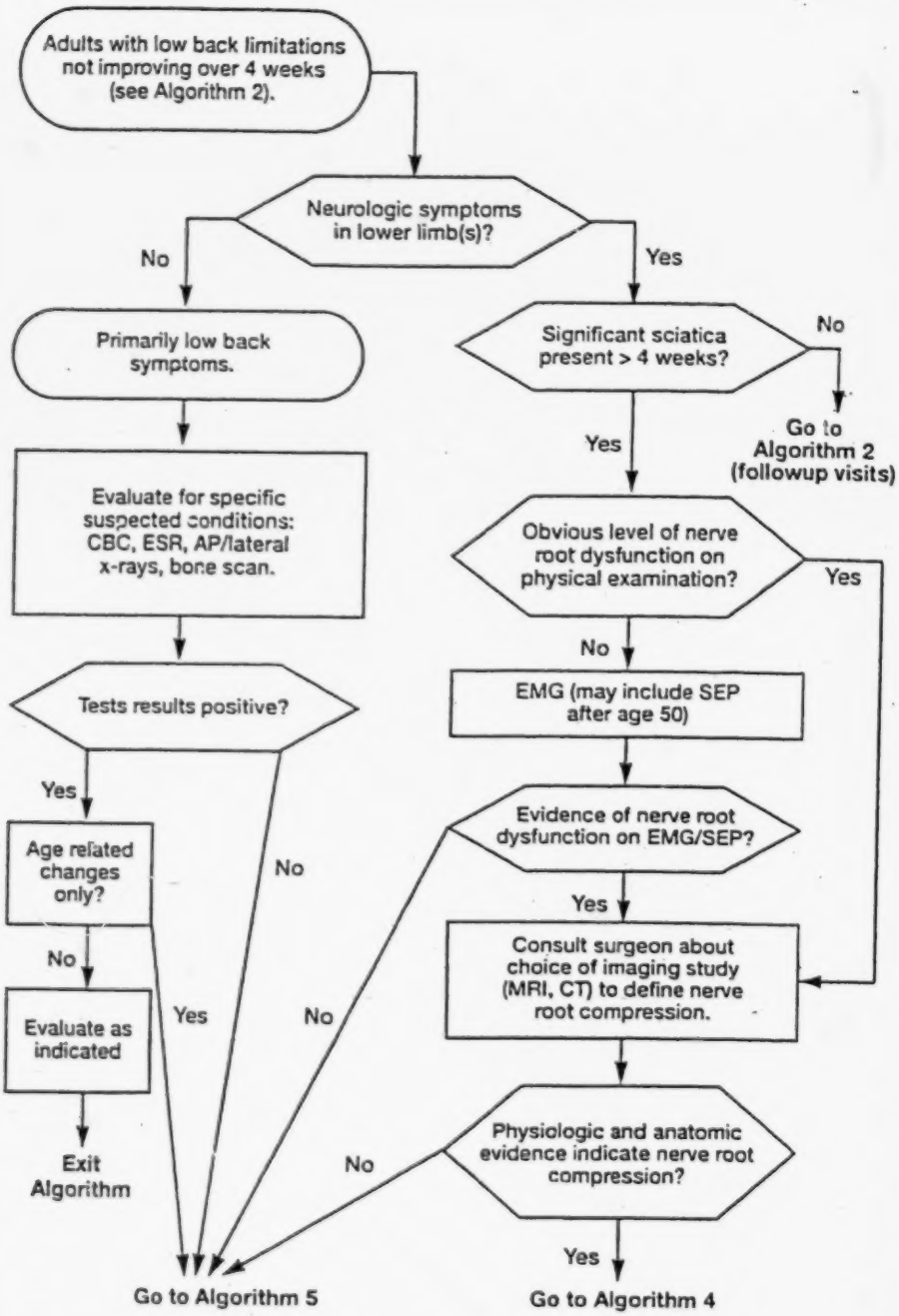
## Algorithm 3. Evaluation of the slow-to-recover patient (symptoms > 4 weeks)



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Definitive treatment for serious conditions (see Table 1) detected by special studies is beyond the scope of this guideline. When special studies fail to define the exact cause of symptoms, however, no patient should receive an impression that the clinician thinks "nothing is wrong" or that the problem could be "in their head." Assure the patient that a clinical workup is highly successful in detecting serious conditions, but does not reveal the precise cause of most low back symptoms.

## Surgical Considerations

Within the first 3 months of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction obviously due to a herniated lumbar disc is detected. A disc herniation, characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis, may trap a nerve root causing irritation, leg symptoms and nerve root dysfunction. The presence of a herniated lumbar disc on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disc herniations that apparently do not entrap a nerve root or cause symptoms.

Therefore, nerve root decompression can be considered for a patient if all of the following criteria exist:

- Sciatica is both severe and disabling.
- Symptoms of sciatica persist without improvement for longer than 4 weeks or with extreme progression.
- There is strong physiologic evidence of dysfunction of a specific nerve root with intervertebral disc herniation confirmed at the corresponding level and side by findings on an imaging study.

Patients with acute low back pain alone, without findings of serious conditions or significant nerve root compression, rarely benefit from a surgical consultation.

Many patients with strong clinical findings of nerve root dysfunction due to disc herniation recover activity tolerance within 1 month; no evidence indicates that delaying surgery for this period worsens outcomes. With or without an operation, more than 80 percent of patients with obvious surgical indications eventually recover. Surgery seems to be a luxury for speeding recovery of patients with obvious surgical indications but benefits fewer than 40 percent of patients with questionable physiologic findings. Moreover, surgery increases the chance of future procedures with higher complication rates. Overall, the incidence of first-time disc surgery complications, including infection and bleeding, is less than 1 percent. The figure increases dramatically with older patients or repeated procedures.



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**Direct and indirect nerve root decompression for herniated discs.** Direct methods of nerve root decompression include laminotomy (expansion of the interlaminar space for access to the nerve root and the offending disc fragments), microdiscectomy (laminotomy using a microscope), and laminectomy (total removal of laminae). Methods of indirect nerve root decompression include chemonucleolysis, the injection of chymopapain or other enzymes to dissolve the inner disc. Such chemical treatment methods are less efficacious than standard or microdiscectomy and have rare but serious complications. Any of these methods is preferable to percutaneous discectomy (indirect, mechanical disc removal through a lateral disc puncture).

**Management of spinal stenosis.** Usually resulting from soft tissue and bony encroachment of the spinal canal and nerve roots, spinal stenosis typically has a gradual onset and begins in older adults. It is characterized by nonspecific limb symptoms, called ***neurogenic claudication*** or ***pseudoclaudication,*** that interfere with the duration of comfortable standing and walking. The symptoms are commonly bilateral and rarely associated with strong focal findings on examination. Neurogenic claudication, however, can be confused or coexist with ***vascular claudication,*** in which leg pain also limits walking. The symptoms of vascular insufficiency can be relieved by simply standing still while relief of neurogenic claudication symptoms usually require the patient to flex the lumbar spine or sit.

The surgical treatment for spinal stenosis is usually complete laminectomy for posterior decompression. Offending soft tissue and osteophytes that encroach upon nerve roots in the central spinal canal and foramen are removed. Fusion may be considered to stabilize a degenerative spondylolisthesis with motion between the slipped vertebra and adjacent vertebrae. Elderly patients with spinal stenosis who tolerate their daily activities usually need no surgery unless they develop new signs of bowel or bladder dysfunction. Decisions on treatment should take into account the patient's preference, lifestyle, other medical problems, and risks of surgery. Surgery for spinal stenosis is rarely considered in the first 3 months of symptoms.

Except for cases of trauma-related spinal fracture or dislocation, fusion alone is not usually considered in the first 3 months following onset of low back symptoms.



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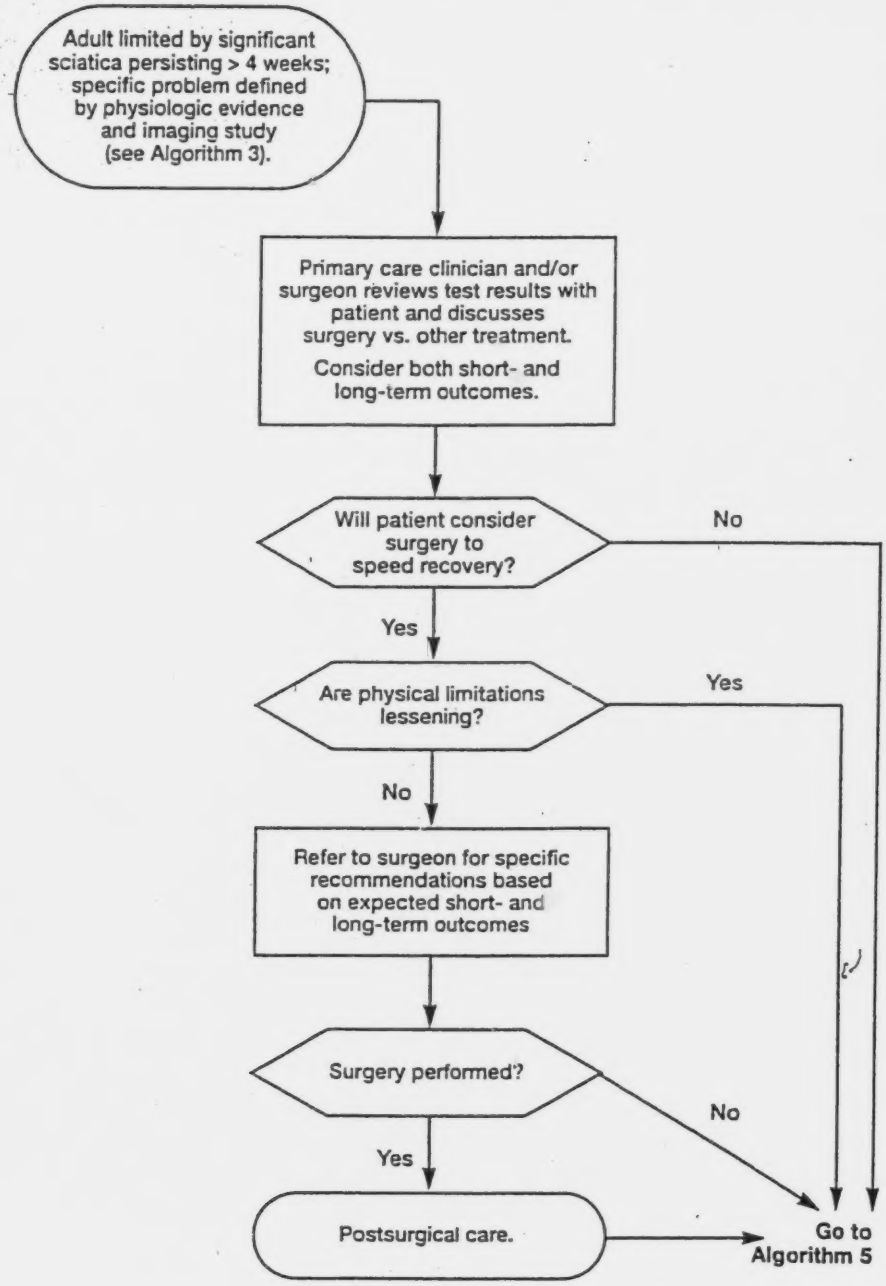
## Algorithm 4. Surgical considerations for patients with persistent sciatica


Adult limited by significant sciatica persisting > 4 weeks; specific problem defined by physiologic evidence and imaging study (see Algorithm 3).
Primary care clinician and/or surgeon reviews test results with patient and discusses surgery vs. other treatment.
Consider both short- and long-term outcomes.
Will patient consider surgery to speed recovery?
No
Yes
Are physical limitations lessening?
Yes
No
Refer to surgeon for specific recommendations based on expected short- and long-term outcomes
Surgery performed?
No
Yes
Postsurgical care.
Go to Algorithm 5

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## Further Management Considerations

Following diagnostic or surgical procedures, the management of most patients becomes focused on improving physical conditioning through an incrementally increased exercise program. The goal of this program is to build activity tolerance and overcome individual limitations due to back symptoms. At this point in treatment, symptom control methods are only an adjunct to making prescribed exercises more tolerable.

- Begin with low-stress aerobic activities to improve general stamina (walking, riding a bicycle, swimming, and eventually jogging).
- Exercises to condition specific trunk muscles can be added a few weeks after. The back muscles may need to be in better condition than before the problem occurred. Otherwise, the back may continue to be painful and easily irritated by even mild activity. Following back surgery, recovery of activity tolerance may be delayed until protective muscles are conditioned well enough to compensate for any remaining structural changes.
- Finally, specific training to perform activities required at home or work can begin. The objective of this program is to increase the patient's tolerance in carrying out actual daily duties.

When patients demonstrate difficulty regaining the ability to tolerate the activities they are required (or would like) to do, the clinician may pose the following diagnostic and treatment questions:

- Could the patient have a serious, undetected medical condition? A careful review of the medical history and physical examination is warranted.
- Are the patient's activity goals realistic? Exploring briefly the patient's expectations, both short- and long-term, of being able to perform specific activities at home, work, or recreation may help the patient assess whether such activity levels are actually achievable.
- If for any reason the achievement of activity goals seems unlikely, what are the patient's remaining options? To answer this question, the patient is often required to gather specific information from family, friends, employers, or others. If, on followup visits, the patient has made no effort to gather such information, the clinician has the opportunity to point out that low back symptoms alone rarely prevent a patient from addressing questions so important to his or her future. This observation can lead to an open, nonjudgmental discussion of common but complicated psychosocial problems or other issues that often can interfere with a patient's recovery from low back problems. The clinician can then help the patient address or arrange further evaluation of any specific problem limiting the patient's progress. This can usually be accomplished as the patient continues, with the clinician's encouragement, to build activity tolerance through safe, simple exercises.



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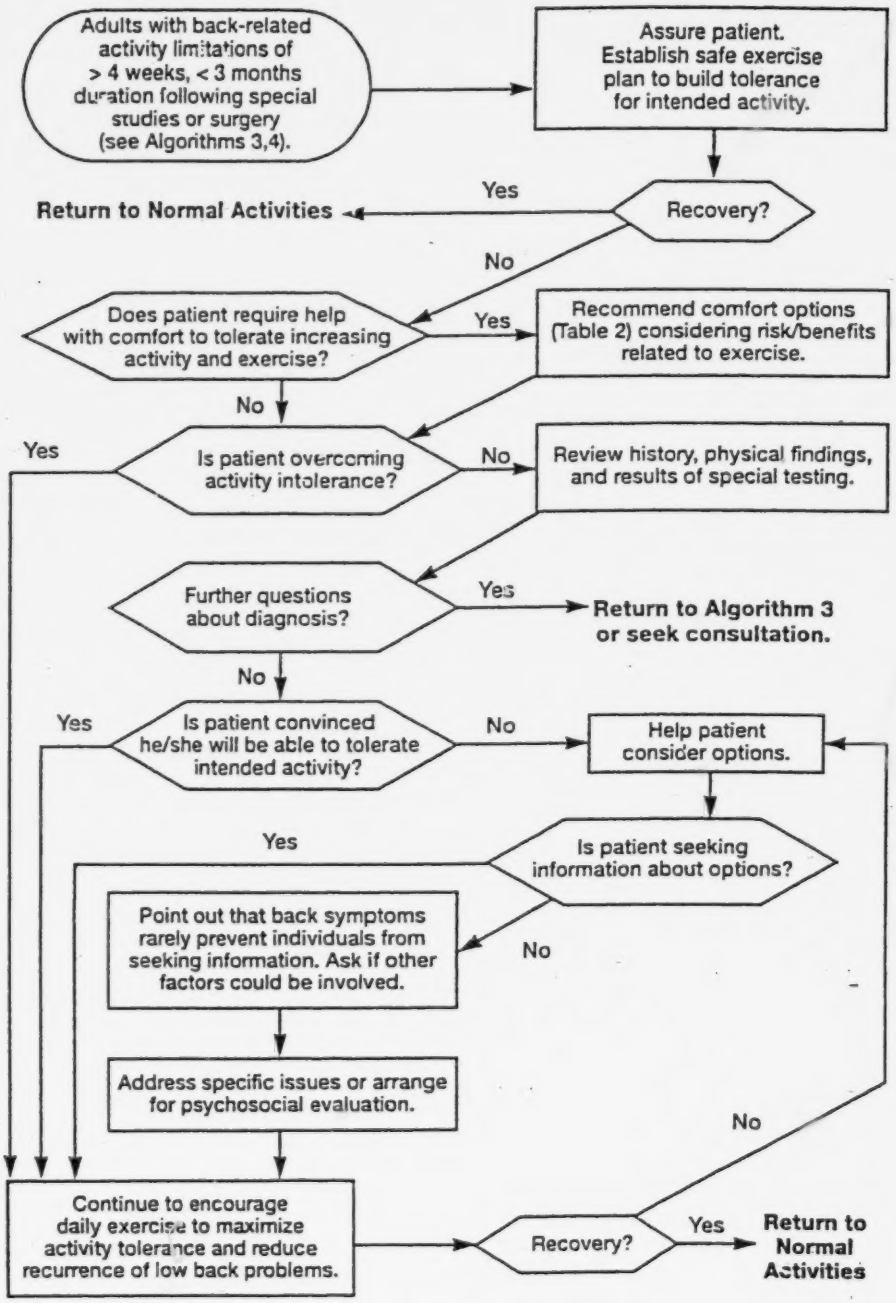
## Algorithm 5. Further management of acute low back problem


Adults with back-related activity limitations of > 4 weeks, < 3 months duration following special studies or surgery (see Algorithms 3,4).
Assure patient. Establish safe exercise plan to build tolerance for intended activity.
Recovery?
Yes
Return to Normal Activities
No
Does patient require help with comfort to tolerate increasing activity and exercise?
Yes
Recommend comfort options (Table 2) considering risk/benefits related to exercise.
No
Is patient overcoming activity intolerance?
Yes
No
Review history, physical findings, and results of special testing.
Further questions about diagnosis?
Yes
Return to Algorithm 3 or seek consultation.
No
Is patient convinced he/she will be able to tolerate intended activity?
Yes
No
Help patient consider options.
Is patient seeking information about options?
Yes
Point out that back symptoms rarely prevent individuals from seeking information. Ask if other factors could be involved.
No
Address specific issues or arrange for psychosocial evaluation.
Continue to encourage daily exercise to maximize activity tolerance and reduce recurrence of low back problems.
Recovery?
No
Yes
Return to Normal Activities

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## Table 5. Summary of Guideline Recommendations

The ratings in parentheses indicate the scientific evidence supporting each recommendation according to the following scale:

A = strong research-based evidence (multiple relevant and high-quality scientific studies).

B = moderate research-based evidence (one relevant, high-quality scientific study or multiple adequate scientific studies).

C = limited research-based evidence (at least one adequate scientific study in patients with low back pain).

D = panel interpretation of evidence not meeting inclusion criteria for research-based evidence.

The number of studies meeting panel review criteria is noted for each category.

| | Recommend | Option | Recommend against |
|---|---|---|---|
| **History and physical exam** 34 studies | Basic history (B).<br>History of cancer/ infection (B).<br>Signs/symptoms of cauda equina syndrome (C).<br>History of significant trauma (C).<br>Psychosocial history (C).<br>Straight leg raising test (B).<br>Focused neurological exam (B). | Pain drawing and visual analog scale(D). | |
| **Patient education** 14 studies | Patient education about low back symptoms (B).<br>Back school in occupational settings (C). | Back school in non-occupational settings (C). | |
| **Medication** 23 studies | Acetaminophen (C).<br>NSAIDs (B). | Muscle relaxants (C).<br>Opioids, short course (C). | Opioids used >2 wks (C).<br>Phenylbutazone (C).<br>Oral steroids (C).<br>Colchicine (B).<br>Antidepressants (C). |
| **Physical treatment methods** 42 studies | Manipulation of low back during first month of symptoms (B). | Manipulation for patients with radiculopathy (C).<br>Manipulation for patients with symptoms >1 month (C).<br>Self-application of heat or cold to low back.<br>Shoe insoles (C).<br>Corset for prevention in occupational setting (C). | Manipulation for patients with undiagnosed neurologic deficits (D).<br>Prolonged course of manipulation (D).<br>Traction (B).<br>TENS (C).<br>Biofeedback (C).<br>Shoe lifts (D).<br>Corset for treatment (D). |
| **Injections** 26 studies | | Epidural steroid injections for radicular pain to avoid surgery (C). | Epidural injections for back pain without radiculopathy (D).<br>Trigger point injections (C).<br>Ligamentous injections (C).<br>Facet joint injections (C).<br>Needle acupuncture (D). |



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| | Recommend | Option | Recommend against |
|---|---|---|---|
| **Bed rest**<br>4 studies | | Bed rest of 2-4 days for severe radiulopathy (D). | Bed rest > 4 days (B). |
| **Activities and exercise**<br>20 studies | Temporary avoidance of activities that increase mechanical stress on spine (D).<br>Gradual return to normal activities (B).<br>Low-stress aerobic exercise (C).<br>Conditioning exercises for trunk muscles after 2 weeks (C).<br>Exercise quotas (C). | | Back-specific exercise machines (D).<br>Therapeutic stretching of back muscles (D). |
| **Detection of physiologic abnormalities**<br>14 studies | If no improvement after 1 month, consider:<br>Bone scan (C).<br>Needle EMG and H-reflex tests to clarify nerve root dysfunction (C).<br>SEP to assess spinal stenosis (C). | | EMG for clinically obvious radiculopathy (D).<br>Surface EMG and F-wave tests (C).<br>Thermography (C). |
| **X-rays of L-S spine**<br>18 studies | When red flags for fracture present (C).<br>When red flags for cancer or infection present (C). | | Routine use in first month of symptoms in absence of red flags (B).<br>Routine oblique views (B). |
| **Imaging**<br>18 studies | CT or MRI when cauda equina, tumor, infection, or fracture strongly suspected (C).<br>MRI test of choice for patients with prior back surgery (D).<br>Assure quality criteria for imaging tests (B). | Myelography or CT-myelography for preoperative planning (D). | Use of imaging test before one month in absence red flags (B).<br>Discography or CT-discography (C). |
| **Surgical considerations**<br>14 studies | Discuss surgical options with patients with persistent and severe sciatica and clinical evidence of nerve root compromise after 1 month of conservative therapy (B).<br>Standard discectomy and microdiscectomy of similar efficacy in treatment of herniated disc (B).<br>Chymopapain, used after ruling out allergic sensitivity, acceptable but less efficacious than discectomy to treat herniated disc (C). | | Disc surgery in patients with back pain alone, no red flags, and no nerve root compression (D).<br>Percutaneous discectomy less efficacious than chymopapain (C).<br>Surgery for spinal stenosis within the first 3 months of symptoms (D).<br>Stenosis surgery when justified by imaging test rather than patient's functional status (D).<br>Spinal fusion during the first 3 months of symptoms in the absence of fracture, dislocation, complications of tumor or infection (C). |
| **Psychosocial factors** | Social, economic, and psychological factors can alter patient response to symptoms and treatment (D). | | Referral for extensive evaluation/treatment prior to exploring patient expectations or psychosocial factors (D). |



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## Availability of Guidelines

For each clinical practice guideline developed under the sponsorship of the Agency for Health Care Policy and Research (AHCPR), several versions are produced to meet different needs.

The *Clinical Practice Guideline* presents recommendations for health care providers with brief supporting information, tables and figures, and pertinent references.

The *Quick Reference Guide for Clinicians* is a distilled version of the *Clinical Practice Guideline*, with summary points for ready reference on a day-to-day basis.

The *Consumer Version*, available in English and Spanish, is an information booklet for the general public to increase patient knowledge and involvement in health care decisionmaking.

To order single copies of guideline products or to obtain further information on their availability, call the AHCPR Publications Clearinghouse toll-free at 800-358-9295 or write to: AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907.

Single copies of the *Clinical Practice Guideline* are available for sale from the Government Printing Office, Superintendent of Documents, Washington, DC 20402, with a 25-percent discount given for bulk orders of 100 copies of more. The *Quick Reference Guide for Clinicians* and the *Consumer Version* in English are also available for sale in bulk quantities only. Call (202) 512-1800 for price and ordering information.

The *Guideline Technical Report* contains complete supporting materials for the *Clinical Practice Guideline*, including background information, methodology, literature review, scientific evidence tables, recommendations for research, and a comprehensive bibliography. It is available from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161. Call (703) 487-4650 for price and ordering information.

The full text of guideline documents for online retrieval may be accessed through a free, electronic service from the National Library of Medicine called HSTAT (Health Services/Technology Assessment Text). Guideline information is also available through some of the computer-based information systems of the National Technical Information Service, professional associations, nonprofit organizations, and commercial enterprises.

A fact sheet describing Online Access for Clinical Practice Guidelines (AHCPR Publication No. 94-0075) and copies of the *Quick Reference Guide for Clinicians* and the *Consumer Version* of each guideline are available through AHCPR's InstantFAX, a fax-on-demand service that operates 24 hours a day, 7 days a week. AHCPR's InstantFAX is accessible to anyone using a facsimile machine equipped with a touchtone telephone handset: Dial (301) 594-2800, push "1," and then press the facsimile machine's start button for instructions and a list of currently available publications.



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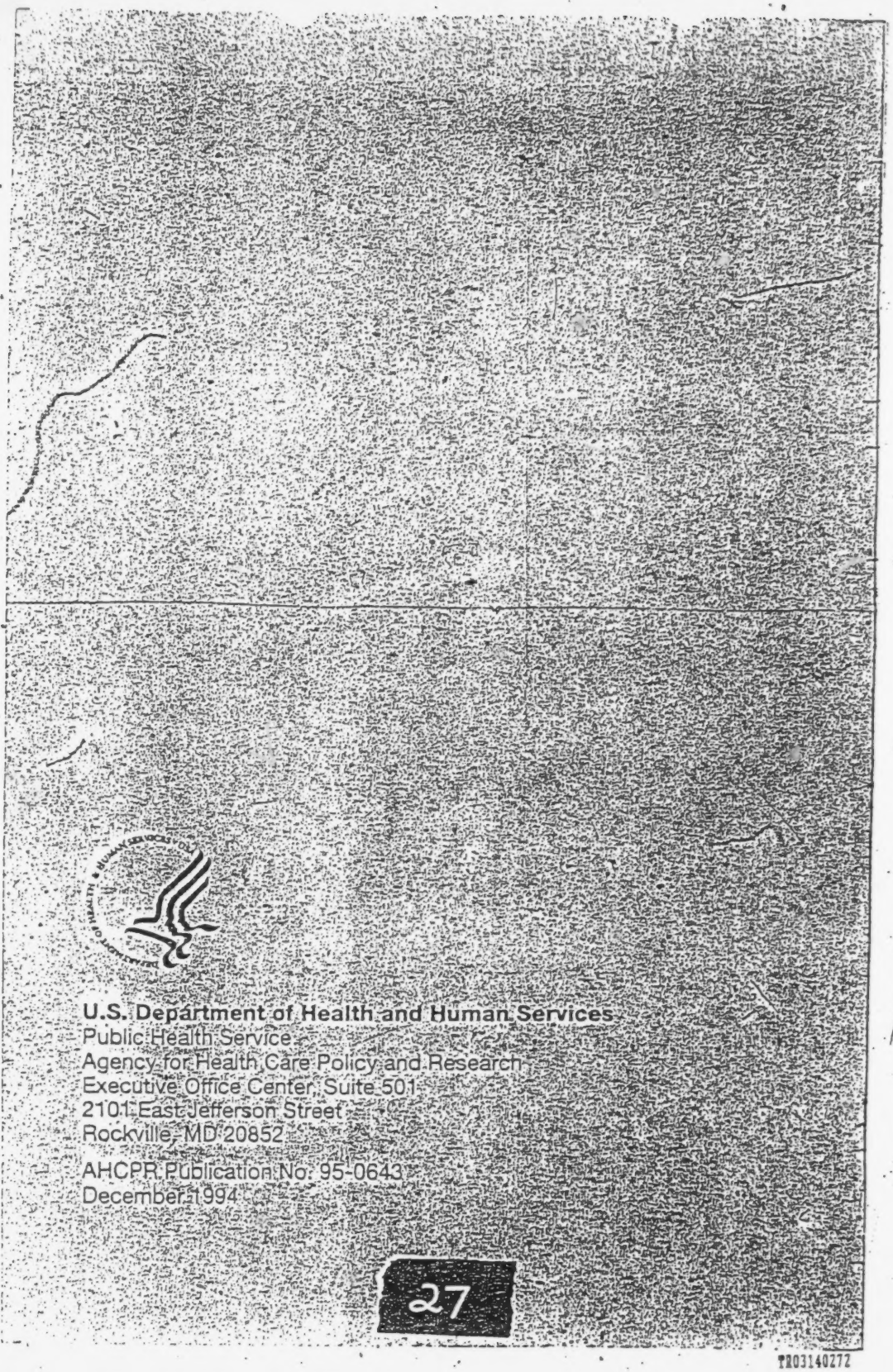

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# Study of Pain Relief Backs Chiropractors

By Tom McNamee
Staff Writer

When it comes to lower back pain, think twice before resorting to the usual remedies—bed rest, prescription drugs and surgery.

Try a chiropractor instead.

The most effective treatment for acute lower back pain, according to a government report to be released today, is a combination of ordinary over-the-counter painkillers —such as Tylenol and aspirin—exercise and spinal manipulation.

The report, which has been circulating in draft form in the medical community, was written by the federal Agency for Health Care Policy and Research, and already is causing a stir. Some health care and physician groups are sniping hard at the report's conclusions, while chiropractors are cheering.

"This is the first time that the United States government has taken a position that is pro-chiropractic, and it is based upon research," said Dr. James Winterstein, president of the National College of Chiropractic in Lombard. "I'm proud of it. This is a watershed moment in our profession."

But the North American Spine Society, an organization whose membership is 70 percent orthopedic surgeons, stressed that the conclusions reached in the report are "untested" and "should serve only as a background" for doctors and patients. In any event, a spokesman for the society said, the report "should not directly dictate or limit" the care that individual patients receive.

Lower back pain is suffered, at one time or another, by up to 80 percent of adult Americans. Next to the common cold, it is the most common reason men and women visit primary care physicians.

The cost of that care is enormous. In 1990, the report says, at least $20 billion was spent on direct medical care for lower back pain. But as much as one-third of that money was "spent for services that did little to help patients." Add in the various indirect costs, such as lost work time and disability payments, and the cost approaches $50 billion.

Specifically, the report recommends the following treatment for lower back pain.

■ The use of acetaminophen (such as Tylenol), and nonsteroidal anti-inflammatory drugs like ibuprofen (such as Advil), naproxen (such as Aleve) and aspirin. Muscle relaxants, commonly prescribed by physicians, are an "option" for "short-term treatment," the authors add, but "appear to be no more effective" than the other medication.

■ Spinal manipulation by a chiropractor, osteopath or other therapist, especially in the first four weeks.

■ Low-stress exercise such as walking, swimming or biking, if the problems are "mild or moderate."

■ More rigorous "conditioning exercises" for the trunk muscles, to start and gradually increase after the first two weeks of pain.

But the report explicitly recommends against certain other common treatments, such as acupuncture, biofeedback and steroid pills, either because the treatment has not been proven effective, could have dangerous side effects or is not worth the money.

Resting in bed for more than four days, for example, could weaken muscles and bones and actually delay recovery, the report says. And spinal traction, another popular remedy, has not been proven successful.

The report discourages surgery within the first three months of the symptoms, unless there is clear evidence of a more serious underlying problem, such as a fracture of the spine. Surgery, the report says, appears to benefit only 1 percent of all people suffering lower back pain.

EXHIBIT
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Los Angeles Times

# Experts Push Low-Tech Care for Back Pain

# BACK: Simple Care Pushed

By MARLENE CIMONS
TIMES STAFF WRITER

WASHINGTON—In a major departure from traditional practice, federal health officials said Thursday that the expensive tests and therapies typically used to diagnose and treat lower back pain are largely useless.

Instead they recommended over-the-counter pain medications, chiropractic and low-stress exercise, such as swimming or walking.

For most patients, symptoms will disappear on their own within a month, they said.

Acute lower back problems—pain or discomfort in the lower back or pain and numbness that moves down the leg (sciatica)—is a sometimes-debilitating condition suffered at some point by almost everyone.

In fact, after the common cold, it is the leading reason that people see their primary-care physicians, according to the federal government.

Back pain can occur at any point on the spine for no apparent reason, but it most commonly crops up in the lower back region because that area bears the majority of the body's weight.

Lower back pain can severely restrict an individual's activities, including the ability to work—sometimes for weeks. In 1990, more than $20 billion in direct medical costs was spent on the condition, mostly for diagnostic tests. The total annual cost—including lost productivity—is estimated at $50 billion.

The new guidelines were compiled by a panel of medical experts who reviewed nearly 4,000 studies. The group was convened by the federal Agency for Health Care Policy and Research, which released the recommendations that are expected to be regarded as the standard of care.

The panel did not address chronic lower back problems, which are the subject of ongoing studies. But it stressed that people with long-term problems represent fewer than 5% of those afflicted with lower back pain. This group may or may not include people with disk problems, depending on the extent or severity of their symptoms.

The guidelines will provide "new hope to those who are confused about the myriad of approaches to acute low back problems," said Dr. Stanley J. Bigos, chairman of the panel and a professor of orthopedic surgery at the University of Washington School of Medicine in Seattle.

The panel said the early use of tests such as X-rays, computed tomography and magnetic resonance imaging should be discouraged unless symptoms indicate more serious underlying conditions, such as fractures, tumors, infections or spinal nerve root problems.

Also, the usual therapies—extended bed rest, muscle relaxants and surgery—can be unnecessary and, in some cases, harmful, the panel said.

Resting in bed for more than four days "can weaken muscles and bones and delay recovery," the panel said.

Within the first three months of symptoms, surgery is only recommended for those with evidence of serious spinal problems or those with certain leg symptoms that result from nerve conditions, dislocations or fractures, the panel said. Surgery appears to benefit only about one out of 100 individuals with acute low back pain, the group said.

Instead, the group said the use of acetaminophen and non-steroidal anti-inflammatory drugs was safe and effective, as was walking, swimming or biking—activities that help maintain and build a patient's tolerance to physical activity.

Chiropractic, which uses spinal manipulation to ease pain, was also found to be helpful, especially within the first four weeks of the onset of pain, the panel said.

The recommendations were a significant validation to the century-old discipline of chiropractic, as well as a rebuff to surgeons.

For many years, chiropractic was the object of criticism and scorn from the medical Establishment, despite growing consumer support. In recent years, however, it has begun to enjoy increasing credibility within mainstream medicine.

Noting that spinal manipulation is a drug-free, non-surgical, low-cost form of relief, Dr. Lawrys Morton, chairman of the board of the American Chiropractic Assn., said he hoped the guidelines would encourage managed-care health plans and health maintenance organizations to include chiropractic within their coverage.

"Spinal manipulation is effective; it gets low back pain patients on their feet and back to work faster than any other form of care," he said.

The panel also recommended ways to prevent back pain. These include engaging in regular exercise; wearing comfortable, low-heeled shoes; using work surfaces at a comfortable height and chairs with good lower back support; and the use of lumbar corsets by people whose jobs require frequent lifting.

Also, when lifting, individuals should avoid twisting, bending and reaching, and keep objects close to the body, the panel said.

**Health Information**

• To hear more information about lower back pain, as well as other problems with muscles, bones and joints, call TimesLine at 808-8463 and press #5190.

Details on Times electronic services, B4

AP photo

front of his own portrait, PLO leader Yasser Arafat
pporters during a rally Thursday in the Gaza Strip.

## 'at's newest test: Fatherhood

o Press

CITY, Gaza—Yasser
going to be a father.
ife, Suha, announced
nancy in an interview
y with Israel Radio's
Service. Her spokes-
said Suha Arafat is one
egnant.
ll, who leaves for
on Friday to receive
el Peace Prize, got the
Prize and the baby."

It will be the first biological child for the 65-year-old Arafat and his wife. They also care for 38 war orphans Arafat brought out of Palestinian refugee camps in Lebanon in the 1980s.

Suha Arafat, was Arafat's secretary before their marriage in November 1991. The marriage was kept secret for 15 months.

Arafat leaves Friday for Oslo,

# Government's approved Rx for back pain: Take a hike

Associated Press

WASHINGTON—Chiropractors get a boost and surgeons a setback in new, government-backed guidelines on how to treat low back pain. For most sufferers, they say, problems will go away on their own within a month.

In the interim, the experts said Thursday, the best advice is to spend no more than two or three days in bed, take over-the-counter painkillers and start moderate, low-stress exercise such as walking or swimming as soon as possible.

The new guidelines for acute low back pain frown on surgery and a host of high-cost tests—including X-rays, CT scans and magnetic resonance imaging—and dismiss as unproven such treatments as spinal traction, biofeedback, transcutaneous electrical nerve stimulation, acupuncture, steroids and injections.

But it says that spinal manipulation, usually performed by a chiropractor, "can be helpful for patients with acute low back problems ... within the first month of symptoms."

Up to 20 percent of adults suffer lower back problems each year, and four out of five will experience-the-agonizing-problem-at least once before their 50th birthday.

The new guidelines offer back sufferers reassurance that "there are safe, effective 'low-tech' ways to feel better and get back to regular activities while your back heals on its own," said Philip Lee, the assistant secretary for health and head of the Public Health Service.

Dr. Stanley Bigos, professor of orthopedic surgery at the University of Washington School of Medicine in Seattle and chairman of the 23-member panel of experts, said the guidelines offer "new hope to those who are confused about the myriad of approaches to acute low back problems."

Too often in the past, Bigos said, doctors have sent patients to bed for extended periods, given them "disorienting painkillers" and ordered "needless, confusing tests."

The experts said surgery helps only 1 in 100 people with sudden back problems. Extensive diagnostic tests are in order only for those patients a doctor suspects might have a fracture, a tumor, an infection or severe nerve involvement.

The guidelines state, "Even having a lot of back pain does not by itself mean you need surgery."

For 9 out of 10 adults, the back problem will go away spontaneously within four weeks.

An ice pack applied to the painful area for five or 10 minutes may help in the first 48 hours. Beyond that, a heating pad or hot shower or bath may work.

For pain relief, acetaminophen or the nonsteroidal anti-inflammatory drugs—aspirin, ibuprofen and naproxen—work just as well as muscle-relaxants or prescription painkillers and are safer.

The experts reviewed more than 3,000 studies in preparing the guidelines for the U.S. Agency for Health Care Policy and Research.

The guidelines do not address chronic back problems.

# Controversial atom bomb stamp scrapped

Associated Press

WASHINGTON—The post office, under heavy White House and diplomatic pressure, is scrapping plans for a stamp recalling the atomic bombing of Japan.

"We are changing the design of the stamp because of the importance of U.S.-Japan relations at this critical time in U.S. foreign policy, and because President Clinton conveyed his views that it was appropriate to do so," Postmaster General Marvin Runyon said Thursday.

The stamp—which was to depict a mushroom cloud following a bomb blast—will be replaced by a design showing President Truman preparing to announce the end of

cials were outraged over the design and filed protests.

The Postal Service initially defended the stamp as commemorating a crucial event in the war that needed to be part of the series of World War II stamps spread over several years.

Runyon said he was particularly mindful of the feelings of veterans—who make up a large part of the postal work force. "Many gave their lives for their country, and we will always be grateful for their paying the ultimate price," Runyon said.

The post office's governing board discussed the controversy at a closed meeting recently and directed Runyon not to change the stamp unless Clinton called for

White House press secretary Dee Dee Myers had commented Wednesday that while the atomic bomb helped speed the end of the war, "there could be more appropriate ways to depict that event."

The State Department had also pointedly urged that the stamp be dropped.

Postal spokesman Robin Wright, releasing Runyon's announcement, said the agency does not want to do anything that would affect the friendship between the U.S. and Japan.

"We believe the long-term interests of the United States are best served by eliminating sore spots when possible," Wright said.

And retired Maj. Gen. Charles W. Sweeney, the pilot of the plane



Nation/World

# Army, A

Associated Press

WASHINGTON—The A
Air Force announced
reductions Thursday tha
lens of thousands from
tary's uniformed and
ranks over the next two

The Army will go fror
active-duty divisions
thousands more positi
the support ranks for a
tion of about 10 percen
next 19 months. Army
fall most heavily on Kan
rado and Texas.

An Air Force plan call

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Comes with 4
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Weather

# The Washington Post

FINAL

116th Year — No. 4 — FRIDAY, DECEMBER 9, 1994 — 25¢

## Barry Plan to Cut $431 Million Targets Police, Schools, Salaries

By Yolanda Woodlee
Washington Post Staff Writer

D.C. Mayor-elect Marion Barry yesterday announced a detailed and wide-ranging economy program for the city to save and generate, starting in fiscal 1995, $431 million in cuts and other measures to help close the District's budget gap for the remainder of fiscal 1995 and for the next five years.

Addressing the District's financial future at a meeting of the City Council, Barry said that he hopes to restore funds eventually for the $431 million that will be cut from the budget, but added that even those cuts will fall short of the $700 million deficit he has estimated the city will face in fiscal 1996.

The package of cuts and revenue increases he unveils the District is close to avoid going broke, but he said it may overlook the 100 layoffs, mid-level officers, from 631 million from the police, schools, and overhead reductions in the plan for $53 million, he does the number of city police officers and cut the number of beds at D.C. General hospital by 50 percent.

The Barry administration has already begun to implement some of the cuts and revenue increases, such as those pertaining to the city's budget. Barry said he will not raise taxes and will not lay off any more workers than he has already announced.

Barry said he is confident that the city will be able to avoid any additional layoffs.

But he cautioned, though, that even if the D.C. Council agrees with all his proposals—some of which lawmakers already have promised to—the city will still be $96 million in the red.

"We will have to do more," Barry said at a briefing at the Dan A. Wilson Building yesterday. "We have to meet Wall Street that we're serious about this.

"I'm not going to run the budget out of existence for inefficiency and ineffective city government," he said. "We're going to make D.C. government more effective, more efficient and more responsive. We're not going to say, 'Well, there we go again.' We can't do that. We're going to do something with the whole budget."

Barry's plan follows previous cutting proposals put forth by outgoing Mayor Sharon Pratt Kelly and Council Chairman David A. Clarke (D) but considered to be the most aggressive yet. Kelly wanted to cut $140 million, and Clarke proposed a plan that would have saved $200 million. Barry's package of $431 million in reductions is made up of the city's $53.2 billion general fund.

The administrative elements of Barry's management restructuring will be presented to the city board meeting on D.C. Council chairman Clarke said that the city needs to narrow the gap between cuts and tax increases to $200 million. Barry's package of $431 million in reductions is made up of the city's $3.2 billion general fund.

The administrative elements of Barry's management restructuring will be presented to the city board meeting on D.C. Council chairman Clarke said that the city needs to narrow the gap between cuts and tax increases to $200 million. Barry's package of $431 million in reductions is made up of the city's $3.2 billion general fund.

See DISTRICT, A10, Col. 1

## White House Considers Cutting a Cabinet Agency

*Aides Prepare Dramatically Slashed Budget*

By Ann Devroy and Jonathan Barr
Washington Post Staff Writers

President Clinton's senior economic and political advisers are preparing budget options that would dramatically slash departments and lead-pipe cinch eliminate a Cabinet department, as the White House, operating with the new Republican Congress in mind, looks for ways to streamline government.

A senior official said last night that while the options include eliminating departments such as Housing and Urban Development and Energy, officials are more concerned with "serious, significant, major restructurings" rather than performing a demolition job.

Republicans, who control the House and Senate, have already said that they intend to do away with the Department of Energy in the fiscal 1996 budget Clinton is preparing to submit to Congress in February. The White House has made clear that it will fight to preserve HUD, which considered a prime candidate for elimination because it has been Henry Cisneros has produced a workable set of proposals that call for "downsizing, reengineering" and "program mission."

See OPTIONS, A18, Col. 5

CAP hears a dissent plan on environmental law. Page 1A

Leaders of Clinton's environmental community. Page 1A

## Down Go the Prices, Up Go Eyebrows

*Retailers Fight for Yule Sales With Unreasonably Sharp Discounts*

By Kenneth Dennis Gonzalez
Washington Post Staff Writer

This holiday season is shaping up as a Grateful Age for consumers, according to retailers, industry analysts and shoppers, who are getting big bargains as a result of prices being slashed in a brutally competitive marketplace.

Retailers have slimmed their costs, maintained their inventories and slashed their prices to respond to today's sophisticated consumers, who have become accustomed to one-of-a-kind prices at wholesale clubs and discount stores, catalogs and airplane seats.

Many shoppers say savoring the experience. As Steven Tanning, a City Place shopping center bar consultant, Lisa C. Crawford, 28, an AT&T employee, purchased the latest line of a mid-range coat offered for $89.99. "You couldn't have found it two years ago at that price," Crawford said, adding that such promotions and sales prices appeal to her because standard prices seem too unreasonable and discounts tend to get more for her dollar.

In a survey of 500 consumers conducted by the Chain Store Age Executive magazine, more than 24,000 stores nationwide, conducted by the Shopper Trak RTM, Mitch Retail Information Corp., Inc., said their sales had increased their prices, and 39 of the 48 said their sales had also risen since 1992 levels. Only three of the 39 said there were unchanged their prices, while seven said their pricing strategy has varied between sales and rack.

Large local retailers are reporting the same trend. Mark Cohen, the manager, which has 42 stores in the Washington area, said prices for photographic chose

See PRICES, A18, Col. 1

## U.S. to Send Forces if U.N. Quits Bosnia

*Ground Troops Would Help in Evacuation*

By Ann Devroy and Bradley Graham
Washington Post Staff Writers

The Clinton administration has made clear that NATO allies and congressional leaders that if it would, provided America ground troops to help evacuate United Nations peacekeeping forces from Bosnia if it withdrawal is requested, U.S. officials said.

The administration position, presented by Clinton and his principal foreign policy advisers, is intended to head off a growing movement in Congress to withdraw U.N. forces from Bosnia, arming the Bosnian government and perhaps using air power against Serbian forces. Some administration officials said the Bosnian government officials said.

Some administration officials said President Clinton had decided on the move. However, as the recommendation of his senior advisers. The decision followed several days of discussions among top U.S. military and civilian officials, who said change of U.N. forces were undertaken.

In both cases, officials said, the administration would remain in the policy it pursued early last year, pressing for a lifting of the arms embargo against the Bosnian Muslims while discouraging aggressive withdrawal of the European forces involved.

See TROOPS, A18, Col. 1

## The Class With Clout

*GOP House Freshmen Are Young, Driven*

By Karen Tumulty and Kenneth J. Cooper
Washington Post Staff Writers

Though their united determination as a class sure caught Democratic leaders off guard, the newly ascendant Republicans in the House of Representatives are not a monolith. Some are fiscal conservatives who want to balance the budget, others are more concerned with social issues. Some are willing to work with the Democrats, others are not.

"There are folks who can run it, let bubbles, and I suspect," said Rep. Steve Stockman (R-Texas), "that there are the message of tomorrow and that the responsibility is to have one to keep the opportunity. I sensed a danger myself in the big groups. But as a general proposition this is a very conservative group. I think I have very mainstream views. This is really an experiment, across ground of people, and that's our goals and objectives."

The class of '94 is younger and more ideologically—range narrower than the class of '92, with fewer

See FRESHMEN, A18, Col. 1

## Back Pain? You Can't Take It Lying Down Anymore

By Sandy Rovner
Washington Post Health Writer

Treating medical problems, a subject of much controversy, is the subject of much controversy, is the subject of much controversy, is the

BY MARY LOU FOY—THE WASHINGTON POST

"You couldn't have found it two years ago at that price," says Lisa C. Crawford of a low-priced coffee machine.

# Down Go the Prices, Up Go Eyebrows

## *Retailers Fight for Yule Sales With Unseasonably Sharp Discounts*

By Kirstin Downey Grimsley
Washington Post Staff Writer

This holiday season is shaping up as a Golden Age for consumers, according to retailers, industry analysts and shoppers who say prices for many goods are steady or even falling because of a bruisingly competitive marketplace.

Retailers have trimmed their costs, restructured their businesses and slashed their prices to appeal to today's tightfisted consumers, who have become accustomed to warehouse-type prices at wholesale clubs and discount stores, retailers and analysts said.

Many shoppers are sensing the opportunity. At Silver Spring's City Place shopping center, for example, Lisa C. Crawford, 38, an AT&T executive, gestured the other day at a mini-espresso coffee machine being offered for $59.99. "You couldn't have found it two years ago at that price," Crawford said, adding that such promotional and sales prices appear to be driving standard prices down for consumers and allowing her to get more for her dollar.

In a survey of 50 retailers representing more than 24,000 stores nationwide, conducted by the Bloomfield Hills, Mich.-based Taubman Centers Inc., 40 said they have not increased their prices, and 20 of the 40 said they have cut them below 1993 levels. Only three of the 50 said they have increased their prices, while seven said their pricing strategy was mixed between hikes and cuts.

Large local retailers are reporting the same trend. Ritz Camera, for example, which has 43 stores in the Washington area, said prices for photography equip-

See PRICES, A10, Col. 1

# ...round Troops Would Help in Evacuation

By Ann Devroy and Bradley Graham
Washington Post Staff Writers

The Clinton administration formally notified NATO allies and congressional leaders yesterday that it would provide American ground troops to help evacuate United Nations peacekeeping forces from Bosnia if a withdrawal is requested, U.S. officials said.

The commitment involves providing about half the evacuation protection force, meaning from 5,000 to 25,000 U.S. troops. A withdrawal would be a highly complex and potentially very dangerous operation for allied forces given Bosnia's mountainous terrain, wide dispersal of U.N. forces and unremitting warfare between separatist Serbs and the Muslim-led government, officials said.

Senior administration officials said President Clinton had decided on the move Tuesday, at the recommendation of his senior advisers. The decision followed several days of discussions about how U.S. policy toward Bosnia would change if U.N. forces were withdrawn.

In such a case, officials said, the administration would return to the policy it pursued early last year, pressing for a lifting of the arms embargo against the Bosnian Muslims while threatening aggressive airstrikes if the Bosnian Serbs attacked

See TROOPS, A41, Col. 1

# Back Pain? You Can't Take It Lying Down Anymore

By Sandy Rovner
Special to The Washington Post

Toppling medical tradition, a panel of medical experts yesterday threw out bed rest and endorsed exercise and spinal manipulation as treatments with proven effectiveness for episodes of acute lower back pain.

The recommendations are part of new government guidelines for treating the most common cause of disability in Americans under the age of 45. To determine which measures have been shown to work for lower back pain, the government-appointed panel evaluated more than 3,900 studies on treatments ranging from spinal fusion surgery to acupuncture. It found that there was no solid scientific evidence to support the use of many popular remedies.

The guidelines were produced by the Agency for Health Care Policy and Research, part of the Department of Health and Human Services. They deal only with the treatment of lower back pain episodes—those that resolve within a month, although they may recur over and over. The guidelines did not consider chronic back pain, which is diagnosed when episodes last three months or longer.

The panel concluded that bed rest probably did more harm than good, and that no data supported the use of biofeedback or acupuncture for back pain. On the other hand, it found that spinal manipulation—a treatment often performed by chiropractors and osteopaths—was safe and effective for patients within the first month of symptoms from an episode of uncomplicated lower back pain.

Many doctors have long discouraged their patients from trying such treatments.

Because nine out of 10 episodes of acute back pain improve on their own within a few weeks, no painkillers stronger than acetamino-

See BACK, A4, Col. 2

# e to Colorado: $120,000

## *Runs Into Flak on Hill (But the Cat Paid)*

...ent at the time, but it is causing trouble now.

...fter a complaint from Capitol ..., Defense Department Acting In...ctor General Derek J. Vander...aaf agreed this week to investi...e the propriety of the flight and ...ther Air Force public affairs per...nel were truthful in answering ...cters' inquiries.

...ahy, who followed Pentagon reg...ions by paying $85 fare for the ... declined to comment.

... spokesman at the Space Com...d in Colorado Springs, Lt. Col. ...nis Gauci, said Ashy and his aide ...idered flying a commercial flight out of Rome on Sept. 10, but worried the schedule would not give him enough time in Colorado the next day to take an eight-hour training course on procedures for alerting the president in event of an air attack.

He was sworn in as head of the Space Command Sept. 13.

Ashy, 54, a 32-year Air Force veteran and fighter pilot, could not leave earlier, the Air Force said, because he was still commander of the 16th Air Force in Italy, a job that included directing air missions over Bosnia.

See FLIGHT, A10, Col. 1

## INSIDE


**No Apologies**
■ Jesse L. Jackson refused to apologize for remarks in which he called the Christian Coalition a "strong force" in Nazi Germany and a racist influence in the slave-holding South.
**NATION**, *Page A2*

**Cubans Riot**
■ A thousand Cuban refugees threw stones at U.S. soldiers, then fled their camps in Panama. Almost all were captured, but about 230 GIs suffered minor injuries.
**WORLD**, *Page A37*

**SEC Trading Suit**
■ The Securities and Exchange Commission yesterday accused two top executives of Rosslyn-based Gannett Co. and the chairman of a major Washington construction company of insider trading. Two of the executives settled the allegations.
**BUSINESS**, *Page F1*


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NATIONAL HEALTH EXPENDITURES BY TYPE OF SERVICE AND SOURCE OF FUNDS: CALENDAR YEARS 1960-02

| LEVELS in $Millions | 2002 | 2001 | 2000 | 1999 | 1998 | 1997 | 1996 | 1995 | 1994 | 1993 | 1992 | 1991 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| National Health Expenditures | 1,553,009 | 1,420,688 | 1,309,444 | 1,222,602 | 1,150,308 | 1,092,784 | 1,039,343 | 990,221 | 937,150 | 888,063 | 827,043 | 761,826 |
| Private Funds | 839,573 | 768,383 | 714,857 | 669,713 | 628,961 | 589,227 | 556,847 | 533,603 | 509,709 | 497,703 | 468,520 | 441,260 |
| Consumer Payments | 762,082 | 696,088 | 641,913 | 597,145 | 558,185 | 522,186 | 495,663 | 476,230 | 455,476 | 445,026 | 419,760 | 396,032 |
| Out-of-pocket Payments | 212,510 | 200,529 | 192,564 | 184,475 | 175,305 | 162,065 | 151,884 | 146,486 | 143,790 | 146,948 | 145,923 | 142,133 |
| Pvt Health Insurance | 549,572 | 495,559 | 449,349 | 412,671 | 382,880 | 360,120 | 343,779 | 329,744 | 311,686 | 298,078 | 273,837 | 253,899 |
| Other Private Funds | 77,492 | 72,295 | 72,944 | 72,568 | 70,777 | 67,042 | 61,184 | 57,373 | 54,232 | 52,678 | 48,760 | 45,228 |
| Industrial Inplant | 4,653 | 4,443 | 4,238 | 3,963 | 3,776 | 3,605 | 3,427 | 3,259 | 3,057 | 2,840 | 2,627 | 2,427 |
| Privately funded const | 16,035 | 13,714 | 13,276 | 12,445 | 12,686 | 12,459 | 10,835 | 10,346 | 11,284 | 11,490 | 10,565 | 9,719 |
| Other Private Revenues Including Philan. | 56,803 | 54,137 | 55,429 | 56,160 | 54,314 | 50,977 | 46,921 | 43,768 | 39,892 | 38,348 | 35,567 | 33,082 |
| Public Funds | 713,436 | 652,305 | 594,586 | 552,888 | 521,347 | 503,557 | 482,496 | 456,618 | 427,441 | 390,360 | 358,523 | 320,565 |
| Federal Funds | 504,717 | 460,274 | 415,951 | 386,442 | 368,429 | 360,155 | 344,836 | 322,393 | 298,934 | 274,373 | 251,113 | 221,678 |
| Medicare | 267,105 | 246,500 | 225,055 | 213,513 | 210,247 | 209,538 | 198,347 | 183,097 | 166,321 | 148,336 | 136,298 | 120,913 |
| Workers' Compensation | 732 | 706 | 663 | 601 | 572 | 565 | 561 | 568 | 600 | 600 | 575 | 530 |
| Public Assistance | 150,477 | 134,159 | 119,703 | 109,056 | 99,800 | 94,837 | 92,127 | 86,177 | 81,299 | 76,762 | 67,957 | 56,694 |
| Medicaid (Title XIX) | 146,558 | 131,142 | 117,644 | 107,945 | 99,562 | 94,837 | 92,127 | 86,177 | 81,299 | 76,762 | 67,957 | 56,694 |
| Medicaid SCHIP Expa | 989 | 883 | 753 | 434 | 111 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 2,930 | 2,134 | 1,306 | 677 | 128 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX Federal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Department of Defense | 17,238 | 15,204 | 13,952 | 12,878 | 12,246 | 12,082 | 11,952 | 12,059 | 11,819 | 12,053 | 11,593 | 11,564 |
| Maternal/Child Health | 626 | 612 | 608 | 605 | 586 | 581 | 580 | 587 | 594 | 578 | 566 | 517 |
| Veterans' Administration | 22,255 | 21,713 | 19,096 | 17,657 | 16,930 | 16,334 | 16,261 | 15,410 | 15,121 | 14,140 | 13,063 | 12,241 |
| Vocational Rehabilitation | 641 | 621 | 594 | 576 | 570 | 563 | 525 | 529 | 521 | 464 | 478 | 452 |
| General Hospital/Medical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gen Hosp/Med NEC | 5,441 | 5,097 | 4,372 | 3,917 | 3,308 | 3,035 | 2,726 | 2,458 | 2,391 | 2,174 | 1,975 | 1,772 |
| ADAMHA/SAMHSA | 2,972 | 2,774 | 2,637 | 2,420 | 1,996 | 1,500 | 1,783 | 2,067 | 1,889 | 1,714 | 1,685 | 1,656 |
| Indian Health Services | 1,934 | 1,905 | 1,757 | 1,616 | 1,560 | 1,570 | 1,467 | 1,520 | 1,361 | 1,379 | 1,349 | 1,127 |
| O.E.O. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Public Health Activity | 7,041 | 5,298 | 4,847 | 4,525 | 4,030 | 3,924 | 3,753 | 3,650 | 3,626 | 3,144 | 2,914 | 2,595 |
| Research | 27,419 | 24,984 | 21,906 | 18,195 | 15,543 | 14,338 | 13,563 | 13,199 | 12,510 | 12,094 | 11,876 | 10,890 |
| Construction | 835 | 700 | 761 | 882 | 1,040 | 1,287 | 1,192 | 1,072 | 882 | 935 | 784 | 726 |
| State and Local Funds | 208,719 | 192,031 | 178,636 | 166,446 | 152,918 | 143,403 | 137,660 | 134,225 | 128,507 | 115,987 | 107,409 | 98,887 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Temporary Disability | 49 | 50 | 48 | 49 | 54 | 58 | 54 | 52 | 53 | 52 | 70 | 66 |
| Workers' Compensation | 29,281 | 26,943 | 24,667 | 22,180 | 20,142 | 19,984 | 21,345 | 21,346 | 21,562 | 21,025 | 20,524 | 18,428 |
| Public Assistance | 109,120 | 98,042 | 89,595 | 82,641 | 76,842 | 69,858 | 65,447 | 63,298 | 57,900 | 49,886 | 45,761 | 41,733 |
| Medicaid (Title XIX) | 102,489 | 91,873 | 84,715 | 78,282 | 71,808 | 64,691 | 60,033 | 57,861 | 52,449 | 44,849 | 40,230 | 36,546 |
| Medicaid SCHIP Expa | 399 | 355 | 293 | 166 | 43 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 1,286 | 950 | 603 | 324 | 64 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX State/Local | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Assistance | 4,945 | 4,864 | 3,983 | 3,869 | 4,928 | 5,167 | 5,414 | 5,437 | 5,451 | 5,037 | 5,531 | 5,187 |
| Maternal/Child Health | 2,185 | 2,148 | 2,068 | 2,003 | 1,832 | 1,764 | 1,683 | 1,625 | 1,568 | 1,504 | 1,465 | 1,430 |
| Vocational Rehabilitation | 202 | 203 | 192 | 189 | 186 | 183 | 180 | 177 | 173 | 155 | 144 | 132 |
| St/L Hosp + School Hlth | 15,177 | 14,005 | 13,372 | 13,730 | 13,757 | 13,341 | 13,515 | 14,107 | 15,300 | 14,185 | 12,733 | 13,070 |
| Public Health Activity | 44,118 | 43,027 | 40,969 | 39,202 | 33,967 | 31,515 | 29,164 | 27,781 | 26,382 | 24,075 | 21,931 | 19,852 |
| Research | 4,197 | 3,820 | 3,469 | 3,081 | 3,017 | 2,792 | 2,661 | 2,496 | 2,298 | 2,119 | 1,988 | 1,890 |
| Construction | 4,390 | 3,792 | 4,254 | 3,370 | 3,121 | 3,908 | 3,611 | 3,344 | 3,271 | 2,987 | 2,793 | 2,286 |
| CMS Programs | | | | | | | | | | | | |
| Total Medicaid (excluding Medicaid SCHIP expansion) | 249,048 | 223,015 | 202,359 | 186,226 | 171,369 | 159,528 | 152,160 | 144,038 | 133,748 | 121,611 | 108,187 | 93,240 |
| Total Medicaid SCHIP expansion and SCHIP | 5,604 | 4,322 | 2,955 | 1,602 | 346 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total CMS Programs (Medicaid, SCHIP and Medicare) | 521,757 | 473,837 | 430,370 | 401,342 | 381,962 | 369,066 | 350,507 | 327,135 | 300,069 | 269,947 | 244,485 | 214,154 |
| POPULATION | 285 | 283 | 280 | 278 | 275 | 273 | 270 | 268 | 265 | 263 | 260 | 257 |
| Health Svcs and Supplies | 1,496,336 | 1,370,040 | 1,261,449 | 1,181,672 | 1,112,057 | 1,055,545 | 1,005,114 | 957,643 | 904,680 | 856,274 | 797,125 | 734,560 |
| Private Funds | 819,741 | 751,032 | 697,253 | 654,313 | 613,430 | 574,314 | 543,644 | 521,136 | 496,200 | 484,049 | 456,044 | 429,786 |
| Consumer Payments | 762,082 | 696,088 | 641,913 | 597,145 | 558,185 | 522,186 | 495,663 | 476,230 | 455,476 | 445,026 | 419,760 | 396,032 |
| Out-of-pocket Payments | 212,510 | 200,529 | 192,564 | 184,475 | 175,305 | 162,065 | 151,884 | 146,486 | 143,790 | 146,948 | 145,923 | 142,133 |
| Pvt Health Insurance | 549,572 | 495,559 | 449,349 | 412,671 | 382,880 | 360,120 | 343,779 | 329,744 | 311,686 | 298,078 | 273,837 | 253,899 |
| Other Private Funds | 57,659 | 54,944 | 55,340 | 57,168 | 55,245 | 52,128 | 47,981 | 44,906 | 40,723 | 39,023 | 36,284 | 33,754 |
| Industrial Inplant | 4,653 | 4,443 | 4,238 | 3,963 | 3,776 | 3,605 | 3,427 | 3,259 | 3,057 | 2,840 | 2,627 | 2,427 |
| Other Private Revenues Including Philan. | 53,006 | 50,500 | 51,102 | 53,204 | 51,469 | 48,523 | 44,554 | 41,647 | 37,667 | 36,183 | 33,657 | 31,327 |
| Public Funds | 676,595 | 619,008 | 564,196 | 527,359 | 498,627 | 481,232 | 461,470 | 436,506 | 408,480 | 372,225 | 341,081 | 304,774 |
| Federal Funds | 476,463 | 434,590 | 393,283 | 367,364 | 351,846 | 344,529 | 330,080 | 308,122 | 285,542 | 261,344 | 238,453 | 210,063 |
| Medicare | 267,105 | 246,500 | 225,055 | 213,513 | 210,247 | 209,538 | 198,347 | 183,097 | 166,321 | 148,336 | 136,298 | 120,913 |
| Workers' Compensation | 732 | 706 | 663 | 601 | 572 | 565 | 561 | 568 | 600 | 600 | 575 | 530 |
| Public Assistance | 150,477 | 134,159 | 119,703 | 109,056 | 99,800 | 94,837 | 92,127 | 86,177 | 81,299 | 76,762 | 67,957 | 56,694 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicaid (Title XIX) | 146,558 | 131,142 | 117,644 | 107,945 | 99,562 | 94,837 | 92,127 | 86,177 | 81,299 | 76,762 | 67,957 | 56,694 |
| Medicaid SCHIP Expa | 989 | 883 | 753 | 434 | 111 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 2,930 | 2,134 | 1,306 | 677 | 128 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX Federal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Department of Defense | 17,238 | 15,204 | 13,952 | 12,878 | 12,246 | 12,082 | 11,952 | 12,059 | 11,819 | 12,053 | 11,593 | 11,564 |
| Maternal/Child Health | 626 | 612 | 608 | 605 | 586 | 581 | 580 | 587 | 594 | 578 | 566 | 517 |
| Veterans' Administration | 22,255 | 21,713 | 19,096 | 17,657 | 16,930 | 16,334 | 16,261 | 15,410 | 15,121 | 14,140 | 13,063 | 12,241 |
| Vocational Rehabilitation | 641 | 621 | 594 | 576 | 570 | 563 | 525 | 529 | 521 | 464 | 478 | 452 |
| General Hospital/Medical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gen Hosp/Med NEC | 5,441 | 5,097 | 4,372 | 3,917 | 3,308 | 3,035 | 2,726 | 2,458 | 2,391 | 2,174 | 1,975 | 1,772 |
| ADAMHA/SAMHSA | 2,972 | 2,774 | 2,637 | 2,420 | 1,996 | 1,500 | 1,783 | 2,067 | 1,889 | 1,714 | 1,685 | 1,656 |
| Indian Health Services | 1,934 | 1,905 | 1,757 | 1,616 | 1,560 | 1,570 | 1,467 | 1,520 | 1,361 | 1,379 | 1,349 | 1,127 |
| O.E.O. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Public Health Activity | 7,041 | 5,298 | 4,847 | 4,525 | 4,030 | 3,924 | 3,753 | 3,650 | 3,626 | 3,144 | 2,914 | 2,595 |
| State and Local Funds | 200,132 | 184,418 | 170,912 | 159,995 | 146,781 | 136,702 | 131,389 | 128,385 | 122,938 | 110,880 | 102,628 | 94,712 |
| Temporary Disability | 49 | 50 | 48 | 49 | 54 | 58 | 54 | 52 | 53 | 52 | 70 | 66 |
| Workers' Compensation | 29,281 | 26,943 | 24,667 | 22,180 | 20,142 | 19,984 | 21,345 | 21,346 | 21,562 | 21,025 | 20,524 | 18,428 |
| Public Assistance | 109,120 | 98,042 | 89,595 | 82,641 | 76,842 | 69,858 | 65,447 | 63,298 | 57,900 | 49,886 | 45,761 | 41,733 |
| Medicaid (Title XIX) | 102,489 | 91,873 | 84,715 | 78,282 | 71,808 | 64,691 | 60,033 | 57,861 | 52,449 | 44,849 | 40,230 | 36,546 |
| Medicaid SCHIP Expa | 399 | 355 | 293 | 166 | 43 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 1,286 | 950 | 603 | 324 | 64 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX State/Local | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Assistance | 4,945 | 4,864 | 3,983 | 3,869 | 4,928 | 5,167 | 5,414 | 5,437 | 5,451 | 5,037 | 5,531 | 5,187 |
| Maternal/Child Health | 2,185 | 2,148 | 2,068 | 2,003 | 1,832 | 1,764 | 1,683 | 1,625 | 1,568 | 1,504 | 1,465 | 1,430 |
| Vocational Rehabilitation | 202 | 203 | 192 | 189 | 186 | 183 | 180 | 177 | 173 | 155 | 144 | 132 |
| St/L Hosp + School Hlth | 15,177 | 14,005 | 13,372 | 13,730 | 13,757 | 13,341 | 13,515 | 14,107 | 15,300 | 14,185 | 12,733 | 13,070 |
| Public Health Activity | 44,118 | 43,027 | 40,969 | 39,202 | 33,967 | 31,515 | 29,164 | 27,781 | 26,382 | 24,075 | 21,931 | 19,852 |
| CMS Programs | | | | | | | | | | | | |
| Total Medicaid (excluding Medicaid expansion) | 249,048 | 223,015 | 202,359 | 186,226 | 171,369 | 159,528 | 152,160 | 144,038 | 133,748 | 121,611 | 108,187 | 93,240 |
| Total Medicaid SCHIP expansion and SCHIP | 5,604 | 4,322 | 2,955 | 1,602 | 346 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total CMS Programs (Medicaid, SCHIP and Medicare) | 521,757 | 473,837 | 430,370 | 401,342 | 381,962 | 369,066 | 350,507 | 327,135 | 300,069 | 269,947 | 244,485 | 214,154 |
| Personal Health Care | 1,340,226 | 1,231,396 | 1,135,324 | 1,064,960 | 1,009,593 | 959,228 | 911,149 | 865,700 | 816,469 | 775,751 | 728,933 | 672,030 |
| Private Funds | 748,059 | 691,438 | 645,532 | 607,088 | 571,704 | 532,668 | 501,349 | 479,502 | 455,354 | 445,252 | 424,214 | 399,777 |
| Consumer Payments | 691,843 | 637,767 | 591,297 | 550,916 | 517,341 | 481,289 | 454,087 | 435,264 | 415,237 | 406,813 | 388,520 | 366,637 |
| Out-of-pocket Payments | 212,510 | 200,529 | 192,564 | 184,475 | 175,305 | 162,065 | 151,884 | 146,486 | 143,790 | 146,948 | 145,923 | 142,133 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pvt Health Insurance | 479,333 | 437,238 | 398,733 | 366,441 | 342,036 | 319,224 | 302,203 | 288,778 | 271,447 | 259,865 | 242,597 | 224,504 |
| Other Private Funds | 56,216 | 53,671 | 54,235 | 56,173 | 54,363 | 51,378 | 47,262 | 44,237 | 40,117 | 38,439 | 35,694 | 33,140 |
| Industrial Inplant | 4,653 | 4,443 | 4,238 | 3,963 | 3,776 | 3,605 | 3,427 | 3,259 | 3,057 | 2,840 | 2,627 | 2,427 |
| Other Private Revenues Including Philan. | 51,563 | 49,227 | 49,997 | 52,209 | 50,587 | 47,773 | 43,835 | 40,978 | 37,061 | 35,599 | 33,067 | 30,713 |
| Public Funds | 592,167 | 539,958 | 489,792 | 457,872 | 437,889 | 426,560 | 409,800 | 386,199 | 361,115 | 330,499 | 304,719 | 272,253 |
| Federal Funds | 450,453 | 412,128 | 371,999 | 347,668 | 334,681 | 329,751 | 316,456 | 295,381 | 273,545 | 250,564 | 229,177 | 201,479 |
| Medicare | 259,099 | 239,212 | 217,466 | 206,173 | 203,994 | 203,554 | 193,085 | 178,649 | 162,066 | 144,355 | 132,844 | 117,638 |
| Workers' Compensation | 708 | 682 | 642 | 583 | 554 | 547 | 544 | 551 | 582 | 584 | 560 | 516 |
| Public Assistance | 140,371 | 125,054 | 111,499 | 101,808 | 93,409 | 90,406 | 87,908 | 81,941 | 77,589 | 73,481 | 65,376 | 54,257 |
| Medicaid (Title XIX) | 137,042 | 122,489 | 109,782 | 100,867 | 93,207 | 90,406 | 87,908 | 81,941 | 77,589 | 73,481 | 65,376 | 54,257 |
| Medicaid SCHIP Expa | 872 | 778 | 662 | 384 | 99 | | | | | | | |
| SCHIP (Title XXI) | 2,457 | 1,787 | 1,055 | 558 | 103 | | | | | | | |
| Non-XIX Federal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Department of Defense | 16,651 | 14,693 | 13,538 | 12,507 | 11,949 | 11,830 | 11,745 | 11,855 | 11,625 | 11,883 | 11,424 | 11,436 |
| Maternal/Child Health | 622 | 608 | 605 | 601 | 582 | 577 | 576 | 583 | 590 | 574 | 562 | 514 |
| Veterans' Administration | 22,161 | 21,621 | 19,015 | 17,583 | 16,861 | 16,266 | 16,190 | 15,336 | 15,042 | 14,057 | 13,006 | 12,187 |
| Vocational Rehabilitation | 567 | 550 | 526 | 511 | 507 | 501 | 470 | 478 | 470 | 411 | 427 | 406 |
| General Hospital/Medical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gen Hosp/Med NEC | 5,441 | 5,097 | 4,372 | 3,917 | 3,308 | 3,035 | 2,726 | 2,458 | 2,391 | 2,174 | 1,975 | 1,772 |
| ADAMHA/SAMHSA | 2,904 | 2,711 | 2,584 | 2,374 | 1,960 | 1,469 | 1,748 | 2,016 | 1,832 | 1,671 | 1,657 | 1,631 |
| Indian Health Services | 1,929 | 1,899 | 1,752 | 1,611 | 1,556 | 1,566 | 1,462 | 1,516 | 1,357 | 1,374 | 1,345 | 1,122 |
| O.E.O. | | | | | | | | | | | | |
| State and Local Funds | 141,713 | 127,830 | 117,793 | 110,204 | 103,208 | 96,809 | 93,344 | 90,817 | 87,570 | 79,934 | 75,542 | 70,773 |
| Temporary Disability | 49 | 50 | 48 | 49 | 54 | 58 | 54 | 52 | 53 | 52 | 70 | 66 |
| Workers' Compensation | 22,524 | 20,621 | 19,034 | 17,294 | 15,742 | 15,172 | 16,022 | 16,177 | 16,578 | 16,942 | 17,701 | 16,329 |
| Public Assistance | 101,768 | 90,992 | 83,261 | 77,116 | 71,807 | 66,464 | 62,054 | 58,839 | 54,052 | 47,248 | 43,572 | 39,881 |
| Medicaid (Title XIX) | 95,396 | 85,019 | 78,532 | 72,830 | 66,789 | 61,297 | 56,640 | 53,401 | 48,601 | 42,211 | 38,041 | 34,694 |
| Medicaid SCHIP Expa | 351 | 311 | 256 | 146 | 38 | | | | | | | |
| SCHIP (Title XXI) | 1,076 | 798 | 489 | 270 | 52 | | | | | | | |
| Non-XIX State/Local | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Assistance | 4,945 | 4,864 | 3,983 | 3,869 | 4,928 | 5,167 | 5,414 | 5,437 | 5,451 | 5,037 | 5,531 | 5,187 |
| Maternal/Child Health | 2,016 | 1,982 | 1,908 | 1,848 | 1,682 | 1,612 | 1,537 | 1,483 | 1,431 | 1,371 | 1,337 | 1,309 |
| Vocational Rehabilitation | 179 | 180 | 170 | 167 | 165 | 163 | 161 | 160 | 156 | 137 | 128 | 118 |
| St/L Hosp + School Hlth | 15,177 | 14,005 | 13,372 | 13,730 | 13,757 | 13,341 | 13,515 | 14,107 | 15,300 | 14,185 | 12,733 | 13,070 |
| CMS Programs | | | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Medicaid (excluding Medicaid expansion) | 232,438 | 207,508 | 188,314 | 173,697 | 159,996 | 151,703 | 144,548 | 135,342 | 126,190 | 115,691 | 103,418 | 88,951 |
| Total Medicaid SCHIP expansion and SCHIP | 4,756 | 3,674 | 2,463 | 1,358 | 292 | | | | | | | |
| Total CMS Programs (Medicaid, SCHIP and Medicare) | 496,293 | 450,394 | 408,243 | 381,228 | 364,282 | 355,257 | 337,633 | 313,991 | 288,256 | 260,046 | 236,262 | 206,589 |
| Hospital Care | 486,511 | 444,316 | 413,178 | 393,464 | 378,535 | 367,613 | 355,210 | 343,580 | 332,398 | 319,962 | 302,267 | 279,485 |
| Private Funds | 200,066 | 181,672 | 170,401 | 160,827 | 152,318 | 143,893 | 138,191 | 136,935 | 135,152 | 136,237 | 130,534 | 126,073 |
| Consumer Payments | 179,757 | 162,598 | 150,222 | 140,332 | 132,594 | 125,882 | 122,358 | 122,238 | 121,925 | 123,739 | 118,954 | 114,954 |
| Out-of-pocket Payments | 14,742 | 13,104 | 12,675 | 12,435 | 11,908 | 11,112 | 10,483 | 10,526 | 11,044 | 12,589 | 12,410 | 11,972 |
| Pvt Health Insurance | 165,015 | 149,494 | 137,547 | 127,897 | 120,686 | 114,770 | 111,875 | 111,712 | 110,881 | 111,150 | 106,544 | 102,982 |
| Other Private Funds | 20,309 | 19,074 | 20,179 | 20,495 | 19,724 | 18,012 | 15,833 | 14,697 | 13,227 | 12,498 | 11,580 | 11,119 |
| Industrial Inplant | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Private Revenues Including Philan. | 20,309 | 19,074 | 20,179 | 20,495 | 19,724 | 18,012 | 15,833 | 14,697 | 13,227 | 12,498 | 11,580 | 11,119 |
| Public Funds | 286,445 | 262,644 | 242,777 | 232,637 | 226,217 | 223,720 | 217,019 | 206,646 | 197,246 | 183,726 | 171,733 | 153,412 |
| Federal Funds | 229,936 | 211,593 | 194,154 | 185,967 | 181,527 | 182,182 | 176,370 | 166,409 | 156,735 | 146,908 | 136,699 | 119,425 |
| Medicare | 149,241 | 137,188 | 126,923 | 122,589 | 121,580 | 122,530 | 115,988 | 107,211 | 98,833 | 90,123 | 84,125 | 73,825 |
| Workers' Compensation | 358 | 348 | 327 | 298 | 287 | 287 | 290 | 295 | 315 | 318 | 306 | 283 |
| Public Assistance | 50,999 | 46,078 | 41,569 | 39,365 | 36,390 | 36,335 | 37,031 | 35,926 | 35,160 | 34,334 | 31,395 | 25,229 |
| Medicaid (Title XIX) | 49,808 | 45,158 | 40,998 | 39,089 | 36,299 | 36,335 | 37,031 | 35,926 | 35,160 | 34,334 | 31,395 | 25,229 |
| Medicaid SCHIP Expa | 289 | 264 | 254 | 150 | 40 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 902 | 656 | 317 | 125 | 51 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX Federal | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Department of Defense | 10,260 | 9,386 | 8,990 | 8,692 | 8,896 | 8,915 | 8,923 | 9,342 | 9,155 | 9,569 | 9,098 | 9,110 |
| Maternal/Child Health | 40 | 41 | 42 | 40 | 43 | 46 | 49 | 53 | 57 | 59 | 61 | 57 |
| Veterans' Administration | 16,592 | 16,259 | 14,409 | 13,329 | 12,837 | 12,609 | 12,694 | 12,198 | 11,925 | 11,239 | 10,465 | 9,814 |
| Vocational Rehabilitation | 299 | 285 | 264 | 241 | 243 | 239 | 231 | 235 | 229 | 180 | 193 | 186 |
| General Hospital/Medi | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gen Hosp/Med NEC | 1,080 | 960 | 657 | 516 | 384 | 344 | 343 | 307 | 309 | 320 | 303 | 280 |
| ADAMHA/SAMHSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 |
| Indian Health Services | 1,067 | 1,050 | 973 | 898 | 867 | 877 | 821 | 842 | 752 | 765 | 752 | 631 |
| O.E.O. | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| State and Local Funds | 56,509 | 51,051 | 48,622 | 46,670 | 44,691 | 41,539 | 40,649 | 40,236 | 40,511 | 36,818 | 35,034 | 33,987 |
| Temporary Disability | 19 | 19 | 19 | 19 | 21 | 23 | 22 | 21 | 22 | 22 | 29 | 28 |
| Workers' Compensation | 9,625 | 8,809 | 8,163 | 7,483 | 6,892 | 6,770 | 7,238 | 7,353 | 7,620 | 7,826 | 8,203 | 7,584 |
| Public Assistance | 35,683 | 32,087 | 30,618 | 28,904 | 27,315 | 24,611 | 22,926 | 21,628 | 20,280 | 17,214 | 16,276 | 15,354 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicaid (Title XIX) | 33,325 | 29,732 | 28,877 | 27,162 | 24,678 | 21,793 | 19,884 | 18,550 | 16,983 | 14,118 | 12,683 | 11,988 |
| Medicaid SCHIP Expa | 121 | 107 | 101 | 59 | 16 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 414 | 303 | 149 | 62 | 26 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX State/Local | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Assistance | 1,824 | 1,945 | 1,492 | 1,621 | 2,595 | 2,818 | 3,042 | 3,079 | 3,298 | 3,096 | 3,593 | 3,366 |
| Maternal/Child Health | 95 | 100 | 103 | 103 | 105 | 113 | 117 | 122 | 126 | 129 | 133 | 135 |
| Vocational Rehabilitation | 94 | 93 | 86 | 81 | 79 | 78 | 79 | 78 | 76 | 60 | 58 | 54 |
| St/L Hosp + School Hlth | 10,993 | 9,941 | 9,634 | 10,081 | 10,278 | 9,944 | 10,265 | 11,033 | 12,387 | 11,567 | 10,334 | 10,831 |
| CMS Programs | | | | | | | | | | | | |
| Total Medicaid (excluding Medicaid expansion) | 83,132 | 74,891 | 69,875 | 66,251 | 60,977 | 58,128 | 56,915 | 54,476 | 52,143 | 48,452 | 44,079 | 37,217 |
| Total Medicaid SCHIP expansion and SCHIP | 1,726 | 1,329 | 821 | 396 | 132 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total CMS Programs (Medicaid, SCHIP and Medicare) | 234,099 | 213,408 | 197,618 | 189,236 | 182,690 | 180,658 | 172,904 | 161,687 | 150,975 | 138,575 | 128,204 | 111,042 |
| Physician and Clinical Services | 339,543 | 315,137 | 290,304 | 270,883 | 256,830 | 240,970 | 229,393 | 220,534 | 210,483 | 201,239 | 189,721 | 175,003 |
| Private Funds | 224,729 | 208,733 | 194,287 | 183,170 | 176,059 | 165,097 | 156,752 | 150,782 | 145,480 | 140,910 | 132,485 | 121,869 |
| Consumer Payments | 201,136 | 186,496 | 172,986 | 160,712 | 154,401 | 145,008 | 137,930 | 133,209 | 129,306 | 126,015 | 118,704 | 109,459 |
| Out-of-pocket Payments | 34,258 | 33,121 | 32,113 | 31,755 | 30,902 | 28,749 | 26,949 | 26,224 | 27,874 | 29,745 | 30,681 | 30,978 |
| Pvt Health Insurance | 166,878 | 153,375 | 140,873 | 128,957 | 123,499 | 116,259 | 110,981 | 106,985 | 101,433 | 96,270 | 88,023 | 78,480 |
| Other Private Funds | 23,594 | 22,237 | 21,301 | 22,458 | 21,659 | 20,089 | 18,822 | 17,574 | 16,174 | 14,895 | 13,781 | 12,411 |
| Industrial Inplant | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Private Revenues Including Philan. | 23,594 | 22,237 | 21,301 | 22,458 | 21,659 | 20,089 | 18,822 | 17,574 | 16,174 | 14,895 | 13,781 | 12,411 |
| Public Funds | 114,814 | 106,405 | 96,018 | 87,713 | 80,771 | 75,872 | 72,641 | 69,752 | 65,003 | 60,329 | 57,236 | 53,134 |
| Federal Funds | 94,742 | 88,128 | 79,659 | 72,744 | 66,770 | 62,350 | 59,166 | 56,416 | 52,100 | 47,821 | 44,942 | 42,167 |
| Medicare | 68,828 | 65,070 | 59,352 | 54,502 | 50,513 | 47,117 | 44,183 | 41,873 | 38,392 | 34,724 | 33,038 | 31,777 |
| Workers' Compensation | 150 | 146 | 137 | 125 | 118 | 115 | 113 | 115 | 121 | 121 | 117 | 108 |
| Public Assistance | 15,392 | 13,527 | 11,784 | 10,679 | 9,915 | 9,567 | 9,268 | 8,678 | 8,114 | 7,641 | 6,613 | 5,290 |
| Medicaid (Title XIX) | 14,452 | 12,790 | 11,272 | 10,345 | 9,871 | 9,567 | 9,268 | 8,678 | 8,114 | 7,641 | 6,613 | 5,290 |
| Medicaid SCHIP Expa | 183 | 163 | 130 | 75 | 19 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 757 | 574 | 382 | 259 | 25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX Federal | | | | | | | | | | | | |
| Department of Defense | 3,605 | 3,048 | 2,689 | 2,219 | 1,667 | 1,626 | 1,589 | 1,571 | 1,579 | 1,693 | 1,631 | 1,666 |
| Maternal/Child Health | 93 | 93 | 93 | 99 | 97 | 97 | 96 | 99 | 101 | 99 | 98 | 91 |
| Veterans' Administration | 1,420 | 1,322 | 1,085 | 972 | 902 | 804 | 738 | 623 | 575 | 533 | 478 | 452 |
| Vocational Rehabilitation | 216 | 215 | 214 | 212 | 218 | 218 | 196 | 199 | 198 | 193 | 195 | 182 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| General Hospital/Medical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gen Hosp/Med NEC | 1,584 | 1,459 | 1,223 | 1,101 | 938 | 899 | 832 | 826 | 815 | 763 | 741 | 668 |
| ADAMHA/SAMHSA | 2,904 | 2,711 | 2,584 | 2,374 | 1,960 | 1,469 | 1,748 | 2,016 | 1,832 | 1,671 | 1,657 | 1,622 |
| Indian Health Services | 550 | 539 | 499 | 462 | 442 | 439 | 403 | 417 | 373 | 381 | 374 | 311 |
| O.E.O. | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| State and Local Funds | 20,072 | 18,277 | 16,358 | 14,970 | 14,000 | 13,522 | 13,475 | 13,336 | 12,904 | 12,508 | 12,294 | 10,967 |
| Temporary Disability | 24 | 25 | 24 | 24 | 27 | 28 | 27 | 25 | 26 | 25 | 34 | 32 |
| Workers' Compensation | 8,889 | 8,205 | 7,585 | 6,882 | 6,255 | 5,947 | 6,250 | 6,323 | 6,464 | 6,595 | 6,898 | 6,363 |
| Public Assistance | 10,934 | 9,819 | 8,524 | 7,839 | 7,506 | 7,342 | 7,005 | 6,797 | 6,226 | 5,705 | 5,184 | 4,399 |
| Medicaid (Title XIX) | 10,028 | 8,989 | 7,818 | 7,220 | 6,864 | 6,706 | 6,381 | 6,164 | 5,613 | 5,049 | 4,539 | 3,823 |
| Medicaid SCHIP Expa | 70 | 63 | 50 | 28 | 7 | | | | | | | |
| SCHIP (Title XXI) | 330 | 257 | 180 | 127 | 13 | | | | | | | |
| Non-XIX State/Local | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Assistance | 506 | 510 | 476 | 464 | 622 | 636 | 625 | 633 | 613 | 656 | 645 | 576 |
| Maternal/Child Health | 157 | 158 | 156 | 153 | 142 | 135 | 126 | 124 | 122 | 119 | 120 | 120 |
| Vocational Rehabilitation | 68 | 70 | 69 | 71 | 71 | 70 | 67 | 67 | 66 | 64 | 59 | 53 |
| St/L Hosp + School Hlth | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CMS Programs | | | | | | | | | | | | |
| Total Medicaid (excluding Medicaid expansion) | 24,480 | 21,779 | 19,090 | 17,566 | 16,734 | 16,273 | 15,649 | 14,842 | 13,728 | 12,690 | 11,152 | 9,113 |
| Total Medicaid SCHIP expansion and SCHIP | 1,340 | 1,056 | 741 | 489 | 64 | | | | | | | |
| Total CMS Programs (Medicaid, SCHIP & Medicare) | 94,648 | 87,905 | 79,183 | 72,556 | 67,311 | 63,390 | 59,831 | 56,715 | 52,119 | 47,415 | 44,190 | 40,890 |
| Dental Services | 70,319 | 65,614 | 60,726 | 56,389 | 53,156 | 50,168 | 46,818 | 44,486 | 41,432 | 38,878 | 37,013 | 33,279 |
| Private Funds | 65,770 | 61,717 | 57,657 | 53,778 | 50,744 | 47,905 | 44,693 | 42,437 | 39,470 | 37,005 | 35,631 | 32,172 |
| Consumer Payments | 65,702 | 61,580 | 57,488 | 53,638 | 50,610 | 47,774 | 44,573 | 42,355 | 39,390 | 36,931 | 35,563 | 32,108 |
| Out-of-pocket Payments | 30,869 | 28,400 | 26,992 | 24,872 | 23,650 | 22,157 | 20,157 | 19,392 | 18,356 | 17,515 | 17,164 | 15,772 |
| Pvt Health Insurance | 34,833 | 33,181 | 30,496 | 28,766 | 26,960 | 25,618 | 24,415 | 22,963 | 21,034 | 19,416 | 18,399 | 16,335 |
| Other Private Funds | 68 | 137 | 169 | 140 | 134 | 130 | 120 | 82 | 80 | 74 | 69 | 65 |
| Industrial Inplant | | | | | | | | | | | | |
| Other Private Revenues Including Philan. | 68 | 137 | 169 | 140 | 134 | 130 | 120 | 82 | 80 | 74 | 69 | 65 |
| Public Funds | 4,549 | 3,898 | 3,069 | 2,611 | 2,412 | 2,263 | 2,125 | 2,049 | 1,962 | 1,873 | 1,382 | 1,107 |
| Federal Funds | 2,715 | 2,314 | 1,838 | 1,550 | 1,444 | 1,314 | 1,223 | 1,151 | 1,094 | 1,070 | 793 | 623 |
| Medicare | 94 | 97 | 104 | 90 | 154 | 88 | 53 | 37 | 24 | 18 | 4 | 2 |
| Workers' Compensation | | | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Public Assistance | 2,479 | 2,078 | 1,603 | 1,344 | 1,180 | 1,115 | 1,082 | 1,001 | 988 | 949 | 878 | 527 |
| Medicaid (Title XIX) | 2,075 | 1,767 | 1,419 | 1,243 | 1,164 | 1,115 | 1,082 | 1,001 | 988 | 949 | 878 | 527 |
| Medicaid SCHIP Expa | 74 | 67 | 55 | 30 | 9 | | | | | | | |
| SCHIP (Title XXI) | 330 | 243 | 130 | 71 | 7 | | | | | | | |
| Non-XIX Federal | | | | | | | | | | | | |
| Department of Defense | 24 | 22 | 22 | 20 | 17 | 17 | 18 | 20 | 20 | 22 | 23 | 24 |
| Maternal/Child Health | 15 | 15 | 15 | 15 | 14 | 14 | 13 | 13 | 13 | 12 | 13 | 11 |
| Veterans' Administration | 14 | 14 | 13 | 11 | 11 | 12 | 12 | 12 | 11 | 9 | 17 | 10 |
| Vocational Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Hospital/Medical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gen Hosp/Med NEC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ADAMHA/SAMHSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Indian Health Services | 89 | 89 | 81 | 71 | 68 | 68 | 64 | 68 | 60 | 59 | 59 | 48 |
| O.E.O. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| State and Local Funds | 1,835 | 1,583 | 1,232 | 1,061 | 968 | 949 | 902 | 898 | 867 | 803 | 589 | 484 |
| Temporary Disability | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Workers' Compensation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Public Assistance | 1,825 | 1,572 | 1,220 | 1,049 | 958 | 939 | 894 | 891 | 861 | 798 | 583 | 478 |
| Medicaid (Title XIX) | 1,616 | 1,398 | 1,101 | 959 | 891 | 869 | 829 | 815 | 782 | 727 | 519 | 419 |
| Medicaid SCHIP Expa | 29 | 28 | 21 | 12 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 138 | 103 | 58 | 33 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX State/Local | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Assistance | 42 | 45 | 41 | 46 | 61 | 70 | 66 | 76 | 79 | 70 | 64 | 60 |
| Maternal/Child Health | 10 | 11 | 12 | 11 | 10 | 10 | 8 | 7 | 7 | 5 | 6 | 5 |
| Vocational Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SVL Hosp + School Hlth | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CMS Programs | | | | | | | | | | | | |
| Total Medicaid (excluding Medicaid expansion) | 3,690 | 3,165 | 2,519 | 2,202 | 2,055 | 1,984 | 1,891 | 1,815 | 1,747 | 1,676 | 1,196 | 945 |
| Total Medicaid SCHIP expansion and SCHIP | 571 | 440 | 263 | 146 | 23 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total CMS Programs (Medicaid, SCHIP and Medicare) | 4,356 | 3,702 | 2,886 | 2,437 | 2,232 | 2,072 | 1,944 | 1,852 | 1,771 | 1,694 | 1,201 | 948 |
| Other Professional Services | 45,852 | 42,633 | 38,791 | 36,652 | 35,496 | 33,378 | 30,877 | 28,555 | 25,669 | 24,478 | 22,185 | 19,694 |
| Private Funds | 33,208 | 31,698 | 29,270 | 28,159 | 27,407 | 25,496 | 23,127 | 21,192 | 18,836 | 18,059 | 16,306 | 14,435 |
| Consumer Payments | 30,206 | 28,769 | 26,377 | 25,161 | 24,260 | 22,502 | 20,321 | 18,573 | 16,426 | 15,840 | 14,252 | 12,586 |
| Out-of-pocket Payments | 13,046 | 12,381 | 11,570 | 11,086 | 10,591 | 9,494 | 8,286 | 7,770 | 7,051 | 6,976 | 6,441 | 5,836 |
| Pvt Health Insurance | 17,160 | 16,388 | 14,808 | 14,075 | 13,669 | 13,008 | 12,035 | 10,803 | 9,375 | 8,863 | 7,811 | 6,750 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Other Private Funds | 3,003 | 2,930 | 2,893 | 2,999 | 3,146 | 2,994 | 2,805 | 2,819 | 2,411 | | | |
| Industrial Inplant | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | |
| Other Private Revenues Including Philan. | 3,003 | 2,930 | 2,893 | 2,999 | 3,146 | 2,994 | 2,805 | 2,819 | 2,411 | | | |
| | | | | | | | | | | 2,220 | 2,054 | 1,850 |
| Public Funds | 12,644 | 10,935 | 9,521 | 8,493 | 8,089 | 7,882 | 7,751 | 7,363 | 6,833 | 0 | 0 | 0 |
| Federal Funds | 8,211 | 7,046 | 5,995 | 5,264 | 5,156 | 5,032 | 4,869 | 4,571 | 4,117 | | | |
| Medicare | 6,444 | 5,655 | 4,783 | 4,158 | 4,125 | 4,001 | 3,896 | 3,720 | 3,341 | 2,220 | 2,054 | 1,850 |
| Workers' Compensation | 169 | 162 | 152 | 138 | 130 | 128 | 126 | 126 | 131 | | | |
| Public Assistance | 1,434 | 1,069 | 901 | 817 | 756 | 761 | 706 | 583 | 501 | 6,418 | 5,879 | 5,259 |
| Medicaid (Title XIX) | 1,344 | 1,009 | 860 | 799 | 753 | 761 | 706 | 583 | 501 | 3,724 | 3,217 | 2,801 |
| Medicaid SCHIP Expa | 34 | 21 | 19 | 8 | 2 | 0 | 0 | 0 | 0 | 2,953 | 2,617 | 2,261 |
| SCHIP (Title XXI) | 56 | 39 | 23 | 10 | 1 | 0 | 0 | 0 | 0 | 130 | 123 | 112 |
| Non-XIX Federal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 501 | 340 | 303 |
| Department of Defense | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 501 | 340 | 303 |
| Maternal/Child Health | 164 | 160 | 159 | 151 | 146 | 142 | 142 | 143 | 14 | 0 | 0 | 0 |
| Veterans' Administration | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Vocational Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Hospital/Medical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gen Hosp/Med NEC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 140 | 137 | 124 |
| ADAMHA/SAMHSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Indian Health Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| O.E.O. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| State and Local Funds | 4,433 | 3,889 | 3,526 | 3,228 | 2,933 | 2,850 | 2,882 | 2,791 | 2,71 | 0 | 0 | 0 |
| Temporary Disability | 3 | 3 | 3 | 3 | 3 | 4 | 3 | 3 | | 0 | 0 | 0 |
| Workers' Compensation | 2,964 | 2,699 | 2,490 | 2,356 | 2,048 | 1,965 | 2,049 | 2,037 | 2,04 | 0 | 0 | 0 |
| Public Assistance | 1,114 | 840 | 699 | 644 | 585 | 597 | 559 | 492 | 42 | 0 | 0 | 0 |
| Medicaid (Title XIX) | 1,012 | 764 | 637 | 586 | 548 | 556 | 513 | 437 | 36 | 2,695 | 2,663 | 2,458 |
| Medicaid SCHIP Expa | 15 | 9 | 7 | 3 | 1 | 0 | 0 | 0 | 0 | 3 | 4 | 3 |
| SCHIP (Title XXI) | 22 | 16 | 10 | 5 | 0 | 0 | 0 | 0 | 0 | 2,070 | 2,126 | 1,942 |
| Non-XIX State/Local | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 385 | 302 | 288 |
| General Assistance | 64 | 51 | 45 | 50 | 36 | 41 | 46 | 54 | 5 | 333 | 254 | 246 |
| Maternal/Child Health | 352 | 347 | 334 | 325 | 297 | 285 | 271 | 260 | 24 | 0 | 0 | 0 |
| Vocational Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| St/L Hosp + School Hlth | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CMS Programs | | | | | | | | | | 51 | 48 | 42 |
| Total Medicaid (excluding Medicaid expansion) | 2,357 | 1,772 | 1,497 | 1,386 | 1,301 | 1,317 | 1,219 | 1,020 | 86 | 237 | 232 | 225 |
| | | | | | | | | | | 0 | 0 | 0 |
| | | | | | | | | | | 0 | 0 | 0 |
| | | | | | | | | | | 834 | 594 | 549 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Medicaid SCHIP expansion and SCHIP | 127 | 85 | 59 | 26 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total CMS Programs (Medicaid, SCHIP and Medicare) | 8,927 | 7,512 | 6,338 | 5,569 | 5,429 | 5,318 | 5,114 | 4,740 | 4,203 | 3,787 | 3,211 | 2,810 |
| Home Health Care | 36,129 | 33,699 | 31,728 | 32,318 | 33,575 | 34,544 | 33,602 | 30,529 | 26,066 | 21,879 | 18,170 | 14,879 |
| Private Funds | 14,278 | 14,140 | 15,267 | 16,461 | 16,307 | 14,796 | 12,944 | 11,191 | 9,528 | 8,501 | 7,398 | 6,647 |
| Consumer Payments | 13,226 | 13,011 | 13,953 | 14,842 | 14,925 | 13,441 | 11,663 | 9,994 | 8,428 | 7,440 | 6,400 | 5,678 |
| Out-of-pocket Payments | 6,493 | 6,104 | 6,237 | 6,673 | 6,623 | 5,946 | 5,147 | 4,403 | 3,709 | 3,275 | 2,819 | 2,507 |
| Pvt Health Insurance | 6,734 | 6,907 | 7,715 | 8,169 | 8,301 | 7,495 | 6,516 | 5,591 | 4,718 | 4,165 | 3,580 | 3,171 |
| Other Private Funds | 1,051 | 1,129 | 1,315 | 1,619 | 1,382 | 1,355 | 1,281 | 1,197 | 1,101 | 1,061 | 998 | 969 |
| Industrial Inplant | | | | | | | | | | | | |
| Other Private Revenues Including Philan. | 1,051 | 1,129 | 1,315 | 1,619 | 1,382 | 1,355 | 1,281 | 1,197 | 1,101 | 1,061 | 998 | 969 |
| Public Funds | 21,852 | 19,559 | 16,461 | 15,857 | 17,268 | 19,748 | 20,658 | 19,338 | 16,537 | 13,378 | 10,772 | 8,233 |
| Federal Funds | 16,184 | 14,362 | 12,071 | 11,658 | 13,193 | 15,850 | 16,962 | 15,801 | 13,313 | 10,489 | 8,179 | 5,973 |
| Medicare | 11,415 | 10,077 | 8,567 | 8,513 | 10,164 | 13,098 | 14,431 | 13,478 | 11,231 | 8,541 | 6,541 | 4,626 |
| Workers' Compensation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Public Assistance | 4,610 | 4,139 | 3,394 | 3,051 | 2,943 | 2,673 | 2,465 | 2,271 | 2,034 | 1,904 | 1,598 | 1,311 |
| Medicaid (Title XIX) | 4,603 | 4,134 | 3,390 | 3,049 | 2,943 | 2,673 | 2,465 | 2,271 | 2,034 | 1,904 | 1,598 | 1,311 |
| Medicaid SCHIP Expa | 3 | 2 | 3 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 4 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX Federal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Department of Defense | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Maternal/Child Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Veterans' Administration | 160 | 146 | 110 | 95 | 86 | 78 | 66 | 52 | 47 | 44 | 39 | 35 |
| Vocational Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Hospital/Medical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gen Hosp/Med NEC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ADAMHA/SAMHSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Indian Health Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| O.E.O. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| State and Local Funds | 5,667 | 5,197 | 4,390 | 4,198 | 4,075 | 3,898 | 3,696 | 3,537 | 3,225 | 2,889 | 2,594 | 2,260 |
| Temporary Disability | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Workers' Compensation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Public Assistance | 3,868 | 3,519 | 2,873 | 2,620 | 2,525 | 2,301 | 2,120 | 2,040 | 1,819 | 1,630 | 1,438 | 1,226 |
| Medicaid (Title XIX) | 3,836 | 3,485 | 2,845 | 2,559 | 2,450 | 2,220 | 2,035 | 1,965 | 1,753 | 1,584 | 1,395 | 1,191 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicaid SCHIP Expa | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX State/Local | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Assistance | 29 | 31 | 26 | 60 | 75 | 81 | 85 | 76 | 66 | 46 | 42 | 35 |
| Maternal/Child Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Vocational Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| St/L Hosp + School Hlth | 1,800 | 1,679 | 1,517 | 1,578 | 1,550 | 1,597 | 1,576 | 1,496 | 1,406 | 1,259 | 1,156 | 1,034 |
| CMS Programs | | | | | | | | | | | | |
| Total Medicaid (excluding Medicaid expansion) | 8,439 | 7,619 | 6,235 | 5,608 | 5,393 | 4,893 | 4,499 | 4,236 | 3,788 | 3,488 | 2,993 | 2,502 |
| Total Medicaid SCHIP expansion and SCHIP | 10 | 7 | 6 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total CMS Programs (Medicaid, SCHIP and Medicare) | 19,864 | 17,703 | 14,807 | 14,123 | 15,557 | 17,992 | 18,931 | 17,714 | 15,019 | 12,029 | 9,535 | 7,128 |
| Other Non-Durable Medical Products | 31,733 | 31,030 | 30,794 | 30,332 | 28,596 | 27,880 | 27,097 | 25,561 | 24,256 | 23,424 | 23,213 | 23,256 |
| Private Funds | 30,139 | 29,560 | 29,476 | 29,142 | 27,407 | 26,710 | 26,003 | 24,475 | 23,337 | 22,575 | 22,432 | 22,567 |
| Consumer Payments | 30,139 | 29,560 | 29,476 | 29,142 | 27,407 | 26,710 | 26,003 | 24,475 | 23,337 | 22,575 | 22,432 | 22,567 |
| Out-of-pocket Payments | 30,139 | 29,560 | 29,476 | 29,142 | 27,407 | 26,710 | 26,003 | 24,475 | 23,337 | 22,575 | 22,432 | 22,567 |
| Pvt Health Insurance | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Public Funds | 1,594 | 1,470 | 1,317 | 1,189 | 1,188 | 1,170 | 1,094 | 1,086 | 920 | 849 | 781 | 689 |
| Medicare | 1,594 | 1,470 | 1,317 | 1,189 | 1,188 | 1,170 | 1,094 | 1,086 | 920 | 849 | 781 | 689 |
| Prescription Drugs | 162,413 | 140,815 | 121,540 | 104,421 | 87,271 | 75,747 | 67,160 | 60,779 | 54,636 | 51,250 | 48,224 | 44,892 |
| Private Funds | 126,173 | 109,323 | 94,879 | 82,220 | 68,832 | 60,024 | 53,350 | 48,534 | 43,839 | 41,636 | 39,525 | 37,136 |
| Consumer Payments | 126,173 | 109,323 | 94,879 | 82,220 | 68,832 | 60,024 | 53,350 | 48,534 | 43,839 | 41,636 | 39,525 | 37,136 |
| Out-of-pocket Payments | 48,605 | 42,503 | 38,324 | 34,361 | 30,485 | 27,874 | 26,497 | 25,970 | 26,315 | 27,031 | 26,377 | 25,241 |
| Pvt Health Insurance | 77,569 | 66,820 | 56,555 | 47,858 | 38,347 | 32,150 | 26,853 | 22,564 | 17,524 | 14,606 | 13,148 | 11,895 |
| Other Private Funds | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Industrial Inplant | | | | | | | | | | | | |
| Other Private Revenues including philan. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Public Funds | 36,239 | 31,492 | 26,661 | 22,201 | 18,439 | 15,723 | 13,810 | 12,245 | 10,797 | 9,614 | 8,700 | 7,756 |
| Federal Funds | 20,866 | 18,042 | 15,306 | 12,755 | 10,504 | 8,952 | 7,763 | 6,632 | 5,760 | 5,127 | 4,464 | 3,836 |
| Medicare | 2,634 | 2,461 | 2,302 | 2,127 | 1,771 | 1,387 | 1,090 | 776 | 521 | 384 | 305 | 250 |
| Workers' Compensation | 28 | 25 | 22 | 19 | 16 | 14 | 13 | 12 | 12 | 12 | 11 | 11 |
| Public Assistance | 16,865 | 14,577 | 12,203 | 10,009 | 8,307 | 7,170 | 6,348 | 5,579 | 5,002 | 4,542 | 3,990 | 3,437 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicaid (Title XIX) | 16,465 | 14,278 | 11,977 | 9,894 | 8,283 | 7,170 | 6,348 | 5,579 | 5,002 | 4,542 | 3,990 | 3,437 |
| Medicaid SCHIP Expa | 144 | 112 | 90 | 49 | 13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 256 | 187 | 135 | 67 | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX Federal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Department of Defense | 1,214 | 880 | 704 | 526 | 348 | 324 | 261 | 214 | 178 | 146 | 114 | 99 |
| Maternal/Child Health | 43 | 39 | 36 | 40 | 35 | 33 | 30 | 28 | 27 | 25 | 25 | 23 |
| Veterans' Administration | 72 | 49 | 30 | 25 | 18 | 14 | 13 | 13 | 11 | 10 | 10 | 10 |
| Vocational Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Hospital/Medical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gen Hosp/Med NEC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ADAMHA/SAMHSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Indian Health Services | 10 | 10 | 9 | 9 | 9 | 9 | 9 | 10 | 9 | 9 | 9 | 7 |
| O.E.O. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| State and Local Funds | 15,373 | 13,450 | 11,355 | 9,446 | 7,935 | 6,771 | 6,047 | 5,613 | 5,038 | 4,487 | 4,235 | 3,920 |
| Temporary Disability | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 2 | 2 |
| Workers' Compensation | 947 | 814 | 707 | 589 | 470 | 414 | 405 | 386 | 372 | 372 | 388 | 361 |
| Public Assistance | 14,288 | 12,511 | 10,539 | 8,762 | 7,393 | 6,302 | 5,598 | 5,190 | 4,635 | 4,088 | 3,820 | 3,531 |
| Medicaid (Title XIX) | 11,943 | 10,393 | 8,791 | 7,352 | 6,132 | 5,197 | 4,551 | 4,163 | 3,650 | 3,184 | 2,894 | 2,607 |
| Medicaid SCHIP Expa | 56 | 43 | 34 | 18 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 105 | 80 | 61 | 31 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX State/Local | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Assistance | 2,184 | 1,995 | 1,653 | 1,361 | 1,251 | 1,105 | 1,047 | 1,027 | 985 | 904 | 927 | 924 |
| Maternal/Child Health | 135 | 123 | 107 | 93 | 70 | 53 | 43 | 36 | 30 | 26 | 25 | 26 |
| Vocational Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| St/L Hosp + School Hlth | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CMS Programs | | | | | | | | | | | | |
| Total Medicaid (excluding Medicaid expansion) | 28,408 | 24,671 | 20,769 | 17,245 | 14,414 | 12,367 | 10,899 | 9,742 | 8,652 | 7,726 | 6,883 | 6,043 |
| Total Medicaid SCHIP expansion and SCHIP | 561 | 423 | 320 | 165 | 35 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total CMS Programs (Medicaid, SCHIP and Medicare) | 31,603 | 27,555 | 23,390 | 19,537 | 16,221 | 13,754 | 11,989 | 10,518 | 9,173 | 8,110 | 7,188 | 6,294 |
| Durable Medical Equipment | 18,754 | 18,162 | 17,750 | 17,231 | 16,851 | 16,157 | 15,284 | 14,185 | 13,322 | 12,797 | 12,229 | 11,397 |
| Private Funds | 11,929 | 12,142 | 12,398 | 12,225 | 12,133 | 11,340 | 10,965 | 10,200 | 9,855 | 9,618 | 9,311 | 8,783 |
| Consumer Payments | 11,929 | 12,142 | 12,398 | 12,225 | 12,133 | 11,340 | 10,965 | 10,200 | 9,855 | 9,618 | 9,311 | 8,783 |
| Out-of-pocket Payments | 8,471 | 8,684 | 8,971 | 8,993 | 8,909 | 8,430 | 8,123 | 7,658 | 7,643 | 7,649 | 7,592 | 7,149 |
| Pvt Health Insurance | 3,459 | 3,458 | 3,427 | 3,232 | 3,224 | 2,910 | 2,842 | 2,541 | 2,212 | 1,969 | 1,719 | 1,634 |
| Other Private Funds | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Industrial Inplant | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Private Revenues Including Philan. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Public Funds | 6,824 | 6,020 | 5,351 | 5,006 | 4,718 | 4,817 | 4,320 | 3,985 | 3,468 | 3,179 | 2,918 | 2,614 |
| Federal Funds | 6,631 | 5,843 | 5,178 | 4,848 | 4,583 | 4,684 | 4,184 | 3,851 | 3,333 | 3,047 | 2,779 | 2,473 |
| Medicare | 5,924 | 5,188 | 4,626 | 4,346 | 4,138 | 4,295 | 3,846 | 3,527 | 3,032 | 2,788 | 2,547 | 2,255 |
| Workers' Compensation | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 | 3 | 3 | 2 | 2 |
| Public Assistance | 60 | 40 | 33 | 17 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Medicaid (Title XIX) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Medicaid SCHIP Expa | 10 | 8 | 12 | 6 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 50 | 32 | 21 | 11 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX Federal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Department of Defense | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Maternal/Child Health | 22 | 21 | 22 | 22 | 21 | 21 | 21 | 21 | 22 | 21 | 21 | 19 |
| Veterans' Administration | 567 | 536 | 442 | 398 | 368 | 315 | 267 | 252 | 229 | 194 | 165 | 156 |
| Vocational Rehabilitation | 52 | 50 | 48 | 59 | 47 | 46 | 43 | 44 | 43 | 38 | 39 | 37 |
| General Hospital/Medical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gen Hosp/Med NEC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ADAMHA/SAMHSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Indian Health Services | 5 | 5 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 3 |
| O.E.O. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| State and Local Funds | 193 | 177 | 173 | 158 | 135 | 132 | 136 | 133 | 135 | 132 | 140 | 141 |
| Temporary Disability | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Workers' Compensation | 99 | 92 | 90 | 85 | 77 | 77 | 80 | 78 | 79 | 81 | 85 | 80 |
| Public Assistance | 39 | 29 | 29 | 21 | 7 | 6 | 7 | 9 | 12 | 10 | 13 | 22 |
| Medicaid (Title XIX) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Medicaid SCHIP Expa | 4 | 3 | 5 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 21 | 13 | 10 | 6 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX State/Local | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Assistance | 14 | 13 | 14 | 12 | 6 | 6 | 7 | 9 | 12 | 10 | 13 | 22 |
| Maternal/Child Health | 38 | 38 | 37 | 37 | 35 | 33 | 32 | 31 | 29 | 28 | 28 | 28 |
| Vocational Rehabilitation | 16 | 17 | 16 | 15 | 15 | 15 | 15 | 15 | 14 | 13 | 12 | 11 |
| St/L Hosp + School Hlth | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CMS Programs | | | | | | | | | | | | |
| Total Medicaid (excluding Medicaid expansion) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Medicaid SCHIP expansion and SCHIP | 85 | 56 | 48 | 26 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total CMS Programs (Medicaid, SCHIP and Medicare) | 6,008 | 5,244 | 4,674 | 4,372 | 4,141 | 4,295 | 3,846 | 3,527 | 3,032 | 2,788 | 2,547 | 2,255 |
| Nursing Home Care | 103,167 | 99,116 | 93,790 | 89,572 | 89,103 | 85,063 | 79,911 | 74,574 | 68,325 | 65,713 | 62,304 | 58,314 |
| Private Funds | 37,113 | 38,010 | 37,659 | 37,143 | 36,722 | 33,801 | 31,899 | 30,496 | 26,800 | 27,869 | 27,965 | 27,667 |
| Consumer Payments | 33,574 | 34,289 | 33,518 | 32,644 | 32,180 | 28,608 | 26,926 | 25,686 | 22,732 | 23,019 | 23,380 | 23,367 |
| Out-of-pocket Payments | 25,888 | 26,674 | 26,206 | 25,156 | 24,829 | 21,594 | 20,239 | 20,067 | 18,461 | 19,593 | 20,008 | 20,111 |
| Pvt Health Insurance | 7,687 | 7,615 | 7,312 | 7,488 | 7,351 | 7,014 | 6,687 | 5,619 | 4,271 | 3,426 | 3,372 | 3,256 |
| Other Private Funds | 3,538 | 3,720 | 4,141 | 4,499 | 4,542 | 5,193 | 4,974 | 4,810 | 4,068 | 4,850 | 4,585 | 4,300 |
| Industrial Inplant | | | | | | | | | | | | |
| Other Private Revenues Including Philan. | 3,538 | 3,720 | 4,141 | 4,499 | 4,542 | 5,193 | 4,974 | 4,810 | 4,068 | 4,850 | 4,585 | 4,300 |
| Public Funds | 66,054 | 61,106 | 56,131 | 52,429 | 52,381 | 51,262 | 48,011 | 44,078 | 41,525 | 37,844 | 34,339 | 30,648 |
| Federal Funds | 45,515 | 42,211 | 37,668 | 34,545 | 35,133 | 34,290 | 31,876 | 28,530 | 26,657 | 24,032 | 21,199 | 18,381 |
| Medicare | 12,925 | 12,005 | 9,494 | 8,659 | 10,361 | 9,867 | 8,505 | 6,942 | 5,773 | 3,976 | 2,885 | 1,954 |
| Workers' Compensation | | | | | | | | | | | | |
| Public Assistance | 30,545 | 28,130 | 26,296 | 24,100 | 23,023 | 22,723 | 21,709 | 19,994 | 19,343 | 18,646 | 17,071 | 15,272 |
| Medicaid (Title XIX) | 30,541 | 28,126 | 26,289 | 24,093 | 23,022 | 22,723 | 21,709 | 19,994 | 19,343 | 18,646 | 17,071 | 15,272 |
| Medicaid SCHIP Expa | 3 | 3 | 7 | 7 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX Federal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Department of Defense | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Maternal/Child Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Veterans' Administration | 2,045 | 2,076 | 1,878 | 1,786 | 1,749 | 1,700 | 1,661 | 1,594 | 1,541 | 1,410 | 1,243 | 1,155 |
| Vocational Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Hospital/Medical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gen Hosp/Med NEC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ADAMHA/SAMHSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Indian Health Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| O.E.O. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| State and Local Funds | 20,539 | 18,895 | 18,463 | 17,884 | 17,248 | 16,973 | 16,136 | 15,548 | 14,868 | 13,812 | 13,140 | 12,267 |
| Temporary Disability | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Workers' Compensation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Public Assistance | 20,539 | 18,895 | 18,463 | 17,884 | 17,248 | 16,973 | 16,136 | 15,548 | 14,868 | 13,812 | 13,140 | 12,267 |
| Medicaid (Title XIX) | 20,354 | 18,723 | 18,294 | 17,721 | 17,090 | 16,845 | 16,015 | 15,440 | 14,746 | 13,730 | 13,071 | 12,206 |
| Medicaid SCHIP Expa | 1 | 1 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SCHIP (Title XXI) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX Federal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Assistance | 184 | 170 | 167 | 161 | 157 | 128 | 121 | 108 | 122 | 82 | 69 | 61 |
| Maternal/Child Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Vocational Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SVL Hosp + School Hlth | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CMS Programs | | | | | | | | | | | | |
| Total Medicaid (excluding Medicaid expansion) | 50,895 | 46,849 | 44,583 | 41,814 | 40,112 | 39,568 | 37,725 | 35,434 | 34,089 | 32,376 | 30,142 | 27,478 |
| Total Medicaid SCHIP expansion and SCHIP | 5 | 6 | 10 | 9 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total CMS Programs (Medicaid, SCHIP and Medicare) | 63,825 | 58,860 | 54,086 | 50,482 | 50,475 | 49,434 | 46,229 | 42,376 | 39,862 | 36,352 | 33,027 | 29,432 |
| Other Per't Hlth Care | 45,803 | 40,874 | 36,724 | 33,698 | 30,181 | 27,708 | 25,798 | 22,918 | 19,881 | 16,130 | 13,605 | 11,829 |
| Private Funds | 4,653 | 4,443 | 4,238 | 3,963 | 3,776 | 3,605 | 3,427 | 3,259 | 3,057 | 2,840 | 2,627 | 2,427 |
| Consumer Payments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Out-of-pocket Payments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pvt Health Insurance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Private Funds | 4,653 | 4,443 | 4,238 | 3,963 | 3,776 | 3,605 | 3,427 | 3,259 | 3,057 | 2,840 | 2,627 | 2,427 |
| Industrial Inplant | 4,653 | 4,443 | 4,238 | 3,963 | 3,776 | 3,605 | 3,427 | 3,259 | 3,057 | 2,840 | 2,627 | 2,427 |
| Other Private Revenues Including Philan. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Public Funds | 41,151 | 36,431 | 32,486 | 29,735 | 26,404 | 24,103 | 22,371 | 19,658 | 16,825 | 13,290 | 10,978 | 9,403 |
| Federal Funds | 24,058 | 21,119 | 18,811 | 17,146 | 15,182 | 13,928 | 12,948 | 10,934 | 9,517 | 7,498 | 6,124 | 5,113 |
| Medicare | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Workers' Compensation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Public Assistance | 17,987 | 15,418 | 13,717 | 12,426 | 10,893 | 10,062 | 9,318 | 7,909 | 6,466 | 4,983 | 3,691 | 2,888 |
| Medicaid (Title XIX) | 17,754 | 15,227 | 13,578 | 12,364 | 10,873 | 10,062 | 9,318 | 7,909 | 6,466 | 4,983 | 3,691 | 2,888 |
| Medicaid SCHIP Expa | 132 | 137 | 92 | 57 | 15 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 101 | 54 | 47 | 14 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX Federal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Department of Defense | 1,848 | 1,397 | 1,133 | 1,081 | 1,022 | 947 | 984 | 707 | 894 | 483 | 557 | 537 |
| Maternal/Child Health | 246 | 240 | 236 | 234 | 226 | 224 | 224 | 225 | 221 | 217 | 208 | 198 |
| Veterans' Administration | 1,291 | 1,220 | 1,048 | 969 | 889 | 733 | 739 | 592 | 702 | 619 | 589 | 555 |
| Vocational Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Hospital/Medical | | | | | | | | | | | | |
| Gen Hosp/Med NEC | 2,777 | 2,679 | 2,192 | 2,300 | 1,986 | 1,792 | 1,550 | 1,325 | 1,267 | 1,090 | 931 | 824 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ADAMHA/SAMHSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Indian Health Services | 208 | 206 | 184 | 168 | 166 | 169 | 163 |
| O.E.O. | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| State and Local Funds | 17,092 | 15,311 | 13,874 | 12,588 | 11,223 | 10,175 | 9,422 |
| Temporary Disability | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Workers' Compensation | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Public Assistance | 13,478 | 11,721 | 10,295 | 9,393 | 8,270 | 7,392 | 6,808 |
| Medicaid (Title XIX) | 13,283 | 11,536 | 10,168 | 9,272 | 8,137 | 7,111 | 6,432 |
| Medicaid SCHIP Expa | 53 | 58 | 35 | 21 | 5 | 0 | 0 |
| SCHIP (Title XXI) | 44 | 24 | 22 | 7 | 3 | 0 | 0 |
| Non-XIX State/Local | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Assistance | 98 | 103 | 69 | 94 | 125 | 281 | 376 |
| Maternal/Child Health | 1,229 | 1,206 | 1,158 | 1,125 | 1,023 | 983 | 940 |
| Vocational Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| St/L Hosp + School Hlth | 2,384 | 2,384 | 2,221 | 2,071 | 1,929 | 1,800 | 1,673 |
| CMS Programs | | | | | | | |
| Total Medicaid (excluding Medicaid expansion) | 31,037 | 26,762 | 23,746 | 21,626 | 19,010 | 17,174 | 15,751 |
| Total Medicaid SCHIP expansion and SCHIP | 331 | 273 | 196 | 99 | 28 | 0 | 0 |
| Total CMS Programs (Medicaid, SCHIP and Medicare) | 31,368 | 27,035 | 23,942 | 21,725 | 19,038 | 17,174 | 15,751 |
| Admin. & Net Cost of Priv. Hlth Insurance | 104,951 | 90,319 | 80,306 | 72,985 | 64,467 | 60,878 | 61,048 |
| Private Funds | 71,682 | 59,594 | 51,722 | 47,225 | 41,726 | 41,646 | 42,295 |
| Consumer Payments | 70,239 | 58,321 | 50,617 | 46,230 | 40,844 | 40,896 | 41,576 |
| Out-of-pocket Payments | | 0 | 0 | 0 | 0 | 0 | 0 |
| Pvt Health Insurance | 70,239 | 58,321 | 50,617 | 46,230 | 40,844 | 40,896 | 41,576 |
| Other Private Funds | 1,443 | 1,273 | 1,105 | 995 | 882 | 750 | 719 |
| Industrial Inplant | | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Private Revenues including Philan | 1,443 | 1,273 | 1,105 | 995 | 882 | 750 | 719 |
| Public Funds | 33,269 | 30,725 | 28,587 | 25,760 | 22,741 | 19,232 | 18,753 |
| Federal Funds | 16,908 | 17,184 | 16,437 | 15,171 | 13,135 | 10,684 | 9,872 |
| Medicare | 8,008 | 7,289 | 7,589 | 7,340 | 6,283 | 5,084 | 5,262 |
| Workers' Compensation | 24 | 24 | 21 | 18 | 18 | 18 | 17 |
| Public Assistance | 10,107 | 9,105 | 8,204 | 7,248 | 6,391 | 4,431 | 4,219 |
| Medicaid (Title XIX) | 9,516 | 8,653 | 7,862 | 7,076 | 6,354 | 4,431 | 4,219 |

| | | | |
|---|---|---|---|
| 0 | 0 | 0 | 0 |
| 159 | 156 | 147 | 121 |
| 0 | 0 | 0 | 0 |
| 7,308 | 5,791 | 4,854 | 4,290 |
| 0 | 0 | 0 | 0 |
| 0 | 0 | 0 | 0 |
| 4,932 | 3,606 | 2,817 | 2,315 |
| 4,714 | 3,484 | 2,686 | 2,215 |
| 0 | 0 | 0 | 0 |
| 0 | 0 | 0 | 0 |
| 0 | 0 | 0 | 0 |
| 217 | 122 | 130 | 101 |
| 869 | 827 | 794 | 770 |
| 0 | 0 | 0 | 0 |
| 1,508 | 1,358 | 1,243 | 1,205 |
| 11,182 | 8,448 | 6,378 | 5,103 |
| 0 | 0 | 0 | 0 |
| 11,182 | 8,448 | 6,378 | 5,103 |
| 58,202 | 53,304 | 43,348 | 40,083 |
| 40,845 | 38,797 | 31,830 | 30,009 |
| 40,239 | 38,213 | 31,240 | 29,395 |
| 0 | 0 | 0 | 0 |
| 40,239 | 38,213 | 31,240 | 29,395 |
| 606 | 584 | 590 | 614 |
| 0 | 0 | 0 | 0 |
| 606 | 584 | 590 | 614 |
| 17,357 | 14,507 | 11,518 | 10,074 |
| 8,371 | 7,636 | 6,363 | 5,988 |
| 4,255 | 3,981 | 3,454 | 3,275 |
| 17 | 17 | 15 | 14 |
| 3,710 | 3,281 | 2,580 | 2,438 |
| 3,710 | 3,281 | 2,580 | 2,438 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicaid SCHIP Expa | 117 | 106 | 91 | 51 | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 473 | 347 | 250 | 119 | 25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX Federal | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Department of Defense | 587 | 510 | 414 | 371 | 297 | 253 | 206 | 204 | 194 | 170 | 170 | 129 |
| Maternal/Child Health | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 3 |
| Veterans' Administration | 93 | 92 | 80 | 74 | 69 | 68 | 71 | 75 | 80 | 83 | 57 | 53 |
| Vocational Rehabilitation | 74 | 71 | 68 | 65 | 63 | 62 | 55 | 51 | 51 | 53 | 51 | 47 |
| General Hospital/Medical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gen Hosp/Med NEC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ADAMHA/SAMHSA | 68 | 64 | 53 | 46 | 36 | 31 | 35 | 51 | 56 | 43 | 27 | 25 |
| Indian Health Services | 5 | 6 | 5 | 5 | 5 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| O.E.O. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| State and Local Funds | 14,301 | 13,561 | 12,149 | 10,589 | 9,606 | 8,378 | 8,881 | 9,787 | 8,986 | 6,871 | 5,155 | 4,086 |
| Temporary Disability | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Workers' Compensation | 6,757 | 6,323 | 5,633 | 4,886 | 4,400 | 4,811 | 5,323 | 5,169 | 4,984 | 4,082 | 2,823 | 2,099 |
| Public Assistance | 7,352 | 7,050 | 6,334 | 5,525 | 5,035 | 3,395 | 3,394 | 4,459 | 3,848 | 2,639 | 2,189 | 1,852 |
| Medicaid (Title XIX) | 7,094 | 6,854 | 6,184 | 5,451 | 5,019 | 3,395 | 3,394 | 4,459 | 3,848 | 2,639 | 2,189 | 1,852 |
| Medicaid SCHIP Expa | 48 | 44 | 36 | 20 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCHIP (Title XXI) | 210 | 152 | 114 | 54 | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-XIX State/Local | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| General Assistance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Maternal/Child Health | 169 | 166 | 160 | 156 | 150 | 152 | 146 | 141 | 137 | 132 | 128 | 122 |
| Vocational Rehabilitation | 23 | 23 | 22 | 22 | 21 | 20 | 19 | 17 | 17 | 18 | 15 | 14 |
| St/L Hosp + School Hlth | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CMS Programs | | | | | | | | | | | | |
| Total Medicaid (excluding Medicaid expansion) | 16,610 | 15,507 | 14,046 | 12,529 | 11,373 | 7,825 | 7,613 | 8,696 | 7,558 | 5,920 | 4,769 | 4,290 |
| Total Medicaid SCHIP expansion and SCHIP | 848 | 648 | 492 | 244 | 54 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total CMS Programs (Medicaid, SCHIP and Medicare) | 25,464 | 23,443 | 22,127 | 20,113 | 17,680 | 13,809 | 12,874 | 13,144 | 11,813 | 9,901 | 8,223 | 7,565 |
| Public Health Activity | 51,159 | 48,325 | 45,817 | 43,728 | 37,997 | 35,439 | 32,916 | 31,430 | 30,009 | 27,219 | 24,845 | 22,447 |
| Federal Funds | 7,041 | 5,298 | 4,847 | 4,525 | 4,030 | 3,924 | 3,753 | 3,650 | 3,626 | 3,144 | 2,914 | 2,595 |
| State/Local Funds | 44,118 | 43,027 | 40,969 | 39,202 | 33,967 | 31,515 | 29,164 | 27,781 | 26,382 | 24,075 | 21,931 | 19,852 |
| Research | 34,307 | 31,495 | 28,777 | 23,374 | 20,535 | 18,717 | 17,833 | 17,094 | 16,252 | 15,587 | 15,048 | 13,871 |
| Private Funds | 2,691 | 2,691 | 3,401 | 2,098 | 1,975 | 1,586 | 1,610 | 1,398 | 1,444 | 1,375 | 1,183 | 1,091 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Business | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Private Revenues Including Philan. | 2,691 | 2,691 | 3,401 | 2,098 | 1,975 | 1,586 | 1,610 | 1,398 | 1,444 | 1,375 | 1,183 | 1,091 |
| Public Funds | 31,617 | 28,804 | 25,375 | 21,276 | 18,560 | 17,131 | 16,224 | 15,696 | 14,808 | 14,213 | 13,865 | 12,780 |
| Federal Funds | 27,419 | 24,984 | 21,906 | 18,195 | 15,543 | 14,338 | 13,563 | 13,199 | 12,510 | 12,094 | 11,876 | 10,890 |
| State/Local Gov't | 4,197 | 3,820 | 3,469 | 3,081 | 3,017 | 2,792 | 2,661 | 2,496 | 2,298 | 2,119 | 1,988 | 1,890 |
| Construction | 22,366 | 19,153 | 19,218 | 17,555 | 17,716 | 18,522 | 16,396 | 15,484 | 16,218 | 16,202 | 14,870 | 13,395 |
| Private Funds | 17,142 | 14,661 | 14,202 | 13,302 | 13,556 | 13,327 | 11,593 | 11,068 | 12,065 | 12,280 | 11,293 | 10,383 |
| Business | 16,035 | 13,714 | 13,276 | 12,445 | 12,686 | 12,459 | 10,835 | 10,346 | 11,284 | 11,490 | 10,565 | 9,719 |
| Other Private Revenues Including Philan. | 1,106 | 947 | 926 | 858 | 869 | 868 | 758 | 722 | 781 | 790 | 727 | 664 |
| Public Funds | 5,224 | 4,492 | 5,016 | 4,253 | 4,160 | 5,195 | 4,803 | 4,416 | 4,153 | 3,922 | 3,577 | 3,012 |
| Federal Funds | 835 | 700 | 761 | 882 | 1,040 | 1,287 | 1,192 | 1,072 | 882 | 935 | 784 | 726 |
| State/Local Gov't | 4,390 | 3,792 | 4,254 | 3,370 | 3,121 | 3,908 | 3,611 | 3,344 | 3,271 | 2,987 | 2,793 | 2,286 |

# Managing Low Back Problems in Adults

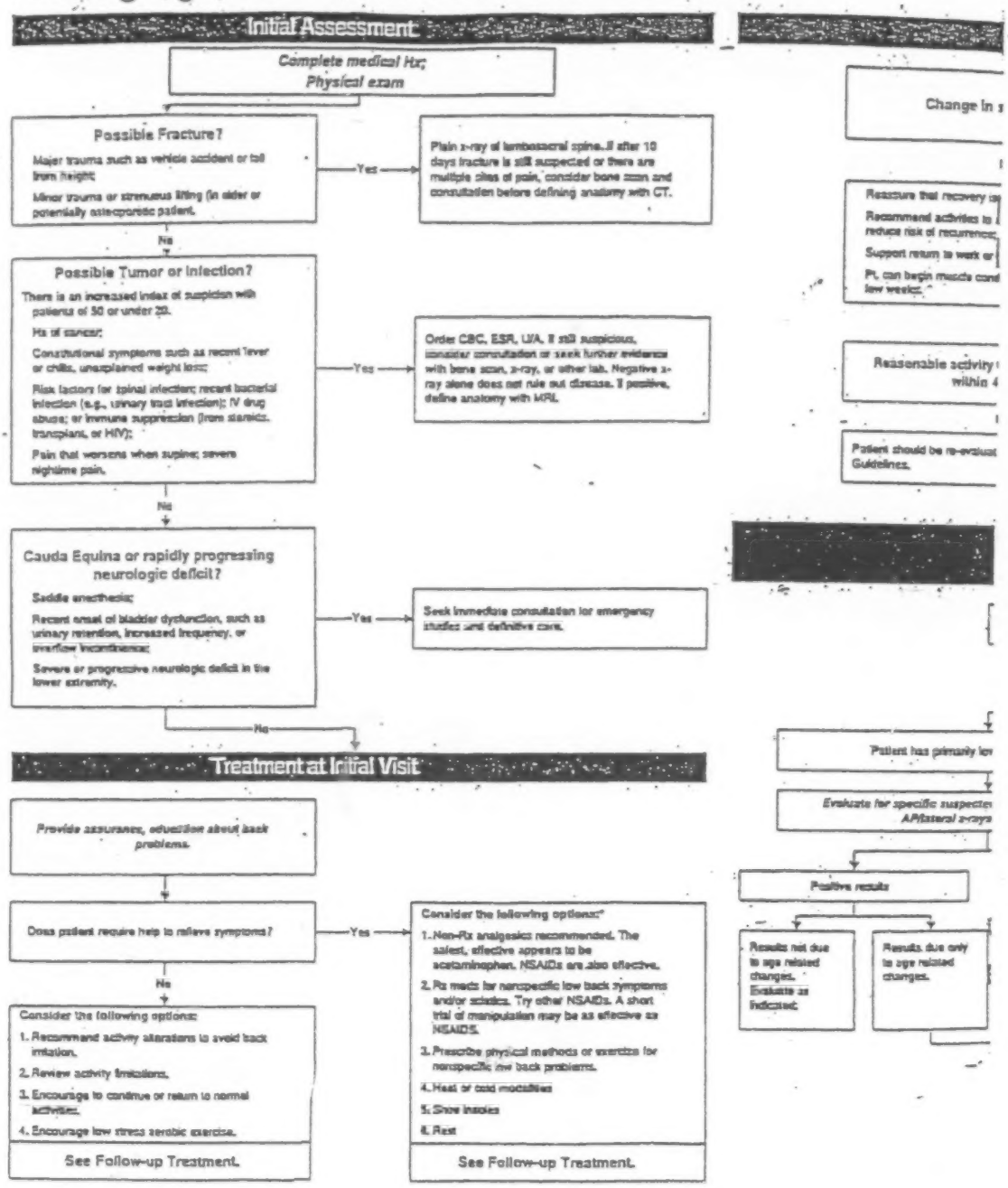
CLINICAL PRACTICE GUIDELINE SERIES

TRIGON

Trigon BlueCross BlueShield

TR11140544

# Managing Low Back Problems in Adults


Initial Assessment
Complete medical Hx;
Physical exam
Possible Fracture?
Major trauma such as vehicle accident or fall from height;
Minor trauma or strenuous lifting (in older or potentially osteoporotic patient.
Yes
Plain x-ray of lumbosacral spine...If after 10 days fracture is still suspected or there are multiple sites of pain, consider bone scan and consultation before defining anatomy with CT.
No
Possible Tumor or Infection?
There is an increased index of suspicion with patients of 50 or under 20.
Hx of cancer;
Constitutional symptoms such as recent fever or chills, unexplained weight loss;
Risk factors for spinal infection; recent bacterial infection (e.g., urinary tract infection); IV drug abuse; or immune suppression (from steroids, transplant, or HIV);
Pain that worsens when supine; severe nighttime pain.
Yes
Order CBC, ESR, UA. If still suspicious, consider consultation or seek further evidence with bone scan, x-ray, or other lab. Negative x-ray alone does not rule out disease. If positive, define anatomy with MRI.
No
Cauda Equina or rapidly progressing neurologic deficit?
Saddle anesthesia;
Recent onset of bladder dysfunction, such as urinary retention, increased frequency, or overflow incontinence;
Severe or progressive neurologic deficit in the lower extremity.
Yes
Seek immediate consultation for emergency studies and definitive care.
No
Treatment at Initial Visit
Provide assurance, education about back problems.
Does patient require help to relieve symptoms?
Yes
Consider the following options:*
1. Non-Rx analgesics recommended. The safest, effective appears to be acetaminophen. NSAIDs are also effective.
2. Rx meds for nonspecific low back symptoms and/or sciatica. Try other NSAIDs. A short trial of manipulation may be as effective as NSAIDS.
3. Prescribe physical methods or exercise for nonspecific low back problems.
4. Heat or cold modalities
5. Shoe inserts
6. Rest
See Follow-up Treatment.
No
Consider the following options:
1. Recommend activity alterations to avoid back irritation.
2. Review activity limitations.
3. Encourage to continue or return to normal activities.
4. Encourage low stress aerobic exercise.
See Follow-up Treatment.
Change in
Reassure that recovery
Recommend activities to reduce risk of recurrence;
Support return to work or
Pt. can begin muscle cond
few weeks.
Reasonable activity within 4
Patient should be re-evaluat Guidelines.
Patient has primarily lo
Evaluate for specific suspecte AP/lateral x-rays
Positive results
Results not due to age related changes. Evaluate as indicated.
Results due only to age related changes.

*Not all contracts cover manipulation, physical methods, exercise or shoe inserts

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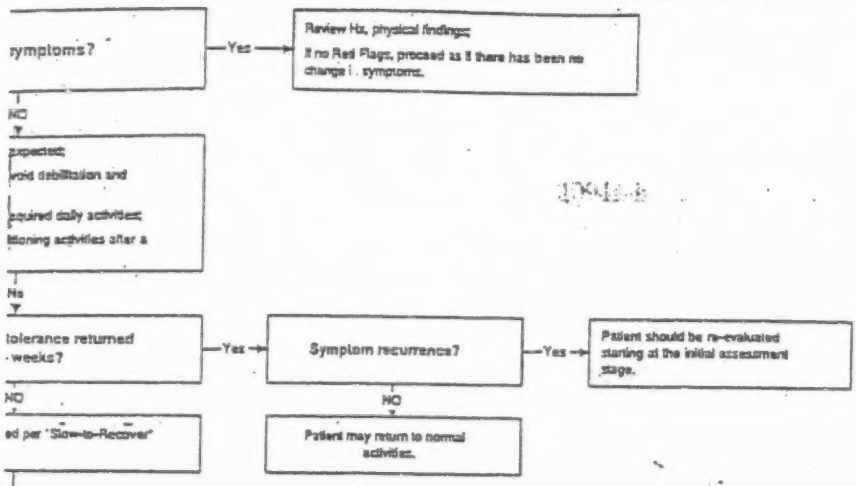
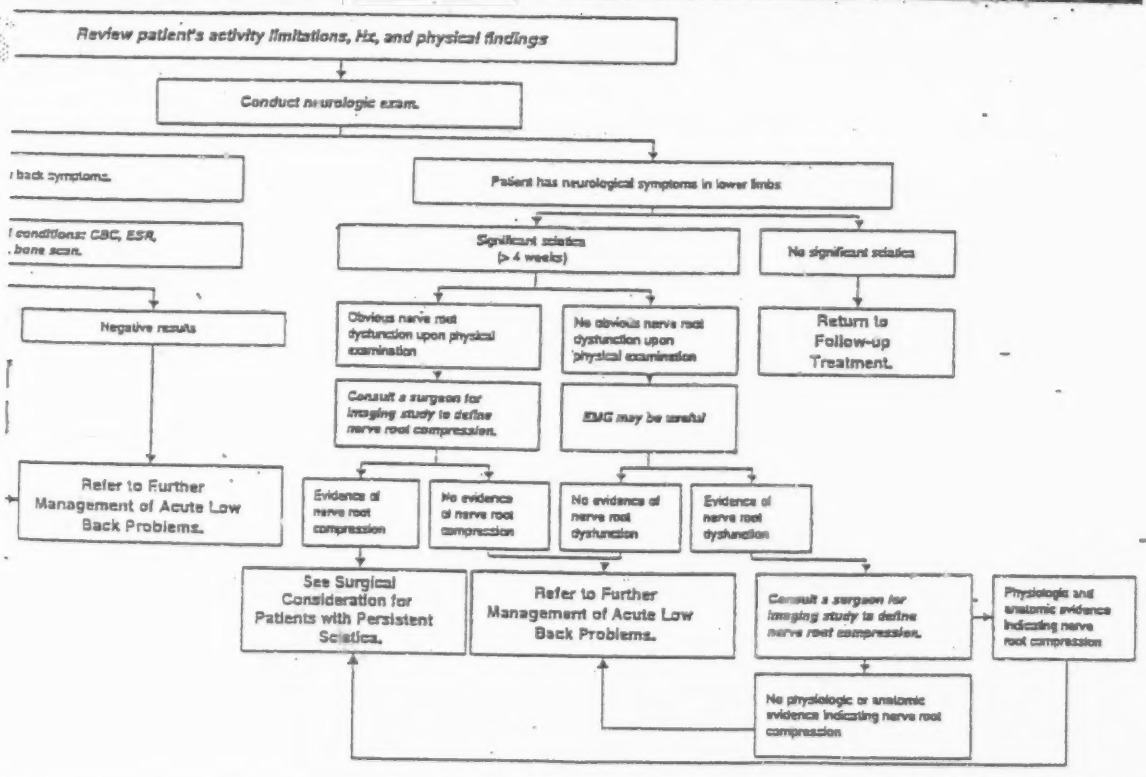
## Follow-up Treatment




## Evaluation of the Slow-to-Recover Patient
(symptoms > 4 weeks)


Review patient's activity limitations, Hx, and physical findings
Conduct neurologic exam.
back symptoms.
conditions: CBC, ESR,
bone scan.
Negative results
Refer to Further Management of Acute Low Back Problems.
Patient has neurological symptoms in lower limbs
Significant sciatica (> 4 weeks)
No significant sciatica
Return to Follow-up Treatment.
Obvious nerve root dysfunction upon physical examination
No obvious nerve root dysfunction upon physical examination
Consult a surgeon for imaging study to define nerve root compression.
EMG may be useful
Evidence of nerve root compression
No evidence of nerve root compression
No evidence of nerve root dysfunction
Evidence of nerve root dysfunction
See Surgical Consideration for Patients with Persistent Sciatica.
Refer to Further Management of Acute Low Back Problems.
Consult a surgeon for imaging study to define nerve root compression.
Physiologic and anatomic evidence indicating nerve root compression
No physiologic or anatomic evidence indicating nerve root compression

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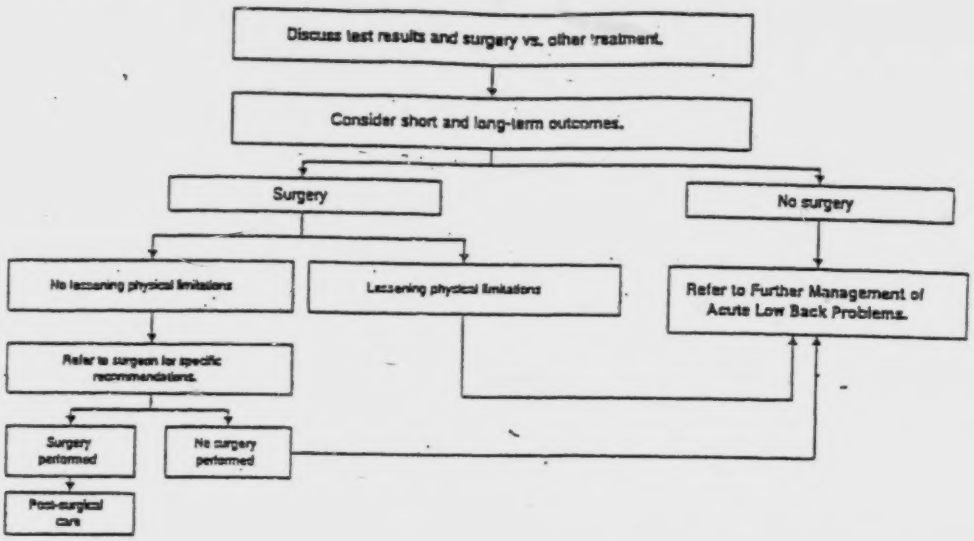
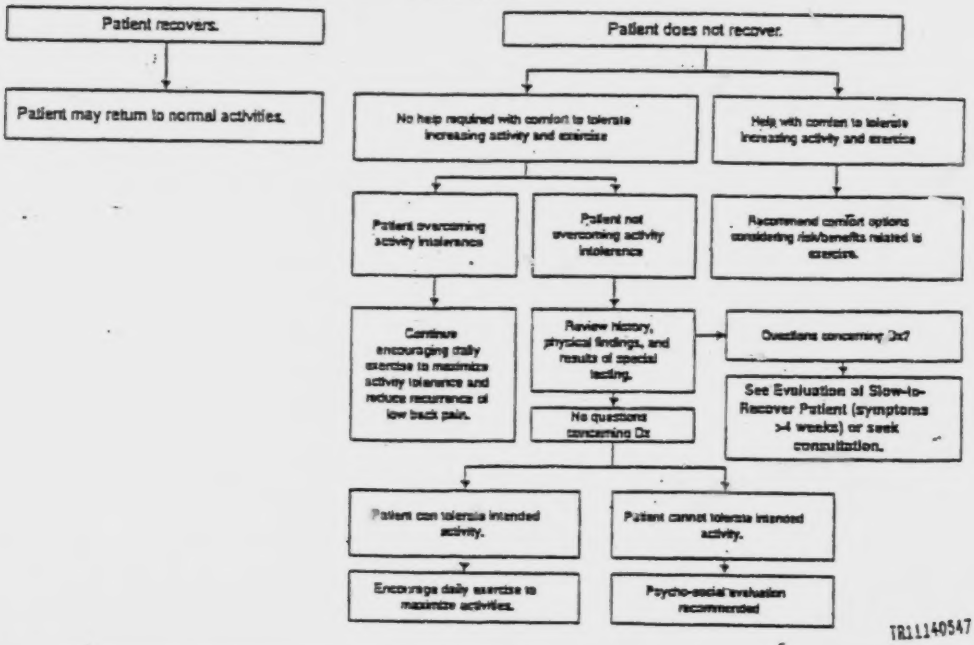
## Surgical Considerations for Patients with Persistent Sciatica


Discuss test results and surgery vs. other treatment.
Consider short and long-term outcomes.
Surgery
No surgery
No lessening physical limitations
Lessening physical limitations
Refer to Further Management of Acute Low Back Problems.
Refer to surgeon for specific recommendations.
Surgery performed
No surgery performed
Post-surgical care

## Further Management of Acute Low Back Problems

**General care following surgery or special studies:**

- For adult patients with back-related activity limitation of more than 4 weeks but less than 3 months duration, see "Evaluation of Slow-to-Recover Patient (symptoms >4 weeks)" and "Surgical Consideration for Patients with Persistent Sciatica."
- Assure patient and establish safe exercise plan to build tolerance for intended activity.


Patient recovers.
Patient may return to normal activities.
Patient does not recover.
No help required with comfort to tolerate increasing activity and exercise
Help with comfort to tolerate increasing activity and exercise
Patient overcoming activity intolerance
Patient not overcoming activity intolerance
Recommend comfort options considering risk/benefits related to exercise.
Continue encouraging daily exercise to maximize activity tolerance and reduce recurrence of low back pain.
Review history, physical findings, and results of special testing.
Questions concerning Dx?
See Evaluation of Slow-to-Recover Patient (symptoms >4 weeks) or seek consultation.
No questions concerning Dx
Patient can tolerate intended activity.
Patient cannot tolerate intended activity.
Encourage daily exercise to maximize activities.
Psycho-social evaluation recommended

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# Trigon Blue Cross Blue Shield's Clinical Practice Guideline Series

## *Managing Acute Low Back Problems*

*The Medical Forum* is pleased to publish Trigon Blue Cross Blue Shield's clinical practice guidelines for managing acute low back problems. These guidelines have been adapted from the Agency for Healthcare Policy and Research (AHCPR) and are approved and endorsed by Trigon's Managed Care Advisory Panel. Trigon's HMOs are finalizing their approval of these guidelines with the intention of creating continuity of guidelines amongst all of Trigon's managed care products.

The AHCPR defines acute low back problems as "activity intolerance due to lower back or back-related symptoms of less than 3 months duration".[1] These recommendations are intended to help the clinician assess common diagnostic and therapeutic interventions for acute low back problems. No sequential approach or clinical pathway for individual patients is implied.

Ninety percent of patients with acute low back problems, as defined here, spontaneously recover activity tolerance within one month. The approach to a new episode in a patient with a recurrent low back problem is similar to that of a new acute episode.

The findings and recommendations included in this guideline define a paradigm shift away from focusing care exclusively on the pain and toward helping patients improve activity tolerance. The guideline provides information on the detection of serious conditions that occasionally cause low back symptoms (conditions such as spinal fracture, tumor, infection, cauda equina syndrome, or non-spinal conditions). However, treatment of these conditions is beyond the scope of this guideline. In addition, the guideline does not address the care of patients younger than 18 years of age or those with chronic back problems (back related activity limitations of greater than 3 months' duration).

The initial assessment stage of the guideline should include two key components: a focused medical history and physical examination. Here are some recommendations for each.

### The Focused Medical History

A patient's estimate of personal activity intolerance due to low back symptoms contributes to the clinical assessment of the severity of the back problem, guides treatment, and establishes a baseline for recommending daily activities and evaluating progress. It should include the following:

- Patient's description of present symptoms and limitations using pain drawings and visual analog pain-rating scales;
- The duration of symptoms;
- A history of previous episodes.

### The Physical Exam

The examination is mostly subjective since patient response or interpretation is required for all parts except reflex testing and circumferential measurements for atrophy. It should include the following:

- General observation of the patient;
- Regional back exam;
- Neurological screening
  - —test for muscle strength
  - —circumferential measurements of the calf and thigh bilaterally to detect muscle atrophy
  - —Reflex testing
  - —Sensory examination;
- Testing for sciatic nerve root tension
  - —straight leg raising test
  - —sitting knee extension test.

In the absence of red flags (see guideline), diagnostic testing is not clinically helpful during the first 4 weeks of symptoms when spontaneous recovery is expected.


Reference

[1]Public Health Service, Agency for Healthcare Policy and Research (1994). Acute Low Back Problems in Adults: Assessment Treatment. AHCPR Publication No. 95-0643. Rockville, MD.


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